HIT Policy Committee
Final Transcript
December 7, 2011

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Thank you very much. Good morning and welcome to the 30th meeting of the HIT Policy Committee. This is Mary Jo Deering of the Office of the National Coordinator for Health Information Technology. This is a public meeting. There will be an opportunity for public comment at the end and a transcript will be made so I will ask the members and anyone else speaking to identify themselves please. And I'll start by taking the roll. Farzad Mostashari is not here but Judy Murphy? Paul Tang?

Paul Tang – Palo Alto Medical Foundation
Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Dr. Agarwal? David Bates?

David Bates - Brigham & Women's Hospital & Partners
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Christine Bechtel? Neil Calman?

Neil Calman – The Institute for Family Health – President and Cofounder
Yes, on the phone, thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Richard Chapman?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Larry Wolf for Richard Chapman.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Larry Wolf, thank you Larry. Adam Clark? Patrick Conway? Art Davidson?

Arthur Davidson – Denver Public Health Department
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Connie Delaney?

Connie White-Delaney – University of Minnesota/School of Nursing – Dean
Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
On the phone. Paul Egerman?

Paul Egerman – Businessman/Entrepreneur
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Judy Faulkner?

Judy Faulkner – EPIC Systems Corporation
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Michael, Captain Weiner? Gayle Harrell?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator
I'm on the phone.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Charles Kennedy? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Frank Nemec? Marc Probst?

Marc Probst – Intermountain Healthcare
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Josh Sharfstein? I think I saw him here. Josh?

Joshua M. Sharfstein – Department of Health & Mental Hygiene, Maryland
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Yeah, I will. Yeah, okay. Latanya Sweeney? Rob Taglicod? Scott White? Okay, I'll turn it over to Paul or Judy Murphy perhaps for the first remarks.

Paul Tang – Palo Alto Medical Foundation
Okay, Judy welcome.

Judy Murphy – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator

Thank you.

Paul Tang – Palo Alto Medical Foundation
In both your new role and stepping in for Farzad this morning. Judy is the new Deputy National Coordinator for Programs and Policy at ONC and so we certainly welcome her to the team and she will be opening up the meeting with her remarks.

Judy Murphy – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator
Thanks Paul. As some of you know I've been on the Standards Committee for 2.5 years actually on the other side of the table in my previous role at Aurora Health Care, so it is interesting to be sitting on this side of the table now. It is only my 3rd day so bear with me. However, a few of my comments are about the exciting time that we're actually in right now. I think we're really passing what many of us would probably refer to as a tipping point and as we head into 2012 I can't emphasize just how exciting I think our industry is going to be in this next 12 months.

So, today you're going to hear from Rob Anthony in terms of the current statistics related to the Medicare and Medicaid EHR incentive program and you can see that we're going to be doing quite good actually now. However, as we head into 2012 I think we have to redouble our efforts to look at adoption and I say that because the statistic that came out just last week was that we have doubled the number of eligible providers that are using electronic health records in the last two years. So the statistic, if you will, in 2009 was about 20% of physicians. Last year it increased to about 30% of physicians and this year it is 40% of physicians. So, again we are well on our way, but our work is of course not done.

So, ONC will be working with CMS to ensure that the numbers really go up significantly in 2012 and some of you may have attended, three weeks ago, the ONC national grantee meeting and at that meeting there was a lot of excitement about going forward and looking at the kinds of things that the regional extension centers and the state-based health IT coordinator's can really do to encourage this effort. And at the end of the day, Farzad laid out actually a challenge to everybody in the room to significantly increase the number of physicians as well as the number of hospitals that are attesting for Meaningful Use through the Medicare Program, but also for the Medicaid Program.

So, the efforts are going to be I think very clearly looking at the providers, especially through those regional extension centers. The providers in our rural areas and the small practices, but we also want to start supporting the big organizations and paying a bit more attention to those big organizations that have maybe both hospitals and eligible providers and making sure that they're getting everything that they need.

One other thing that happened at that meeting, David Blumenthal gave a talk and there was something that he said that I'd like to share with you for those of you who weren't there and that is he talked about the inevitability of where we're sitting today, that when we started this journey a couple of years ago I think we were all wondering when this was going to be happening and if it was even going to happen and I think that's really changed, and that is what he spent a bit of time talking about, and that draws me back to that tipping point idea, that there is this sense of this is going to happen, it's just really a matter of when now, and that we don't worry as much day-to-day, minute-to-minute about talking people into doing it, we have to really spend our time helping them do it. Helping them figure out what they need to be able to achieve Meaningful Use.

So, now as we go forward, I think the challenge in addition to this adoption effort and looking at our efforts relating to that in 2012, we're really going to have to turn our sights to the other big challenge that we've got that I know many of you in this room and on the phone are in agreement with and that is our standards and interoperability efforts. Today we're going to be getting an update from NCVHS related to that. I think, again, many of you know that there's been a lot of work done in this area, but there is a lot more work to do. So, again, this is really an area that's going to be a priority for me. It is a priority for ONC and we have to be able to move from where we are today with our very, you know, limited, if you

will, implementations through our programs to really looking at what it's going to take to get to the nationwide health information architecture.

That being said, you can never just say there's one priority, we do have to worry, of course or continue to think about privacy and security usability, and lastly clinical decision support. It's certainly another area that we're going to be focusing on as we move into 2012. I'll close by saying I think, again, exciting times and I think we can see that success is just around the corner and again that it's inevitable at this point and with that I'll turn it back to Paul.

Paul Tang – Palo Alto Medical Foundation
Thank you so much Judy and it is clear that even in your first three days you bring with you the excitement that you've always had through your career and just like hitting the ground running. So, thank you so much it's going to be a pleasure to work with you.

Let me review some of the rest of the agenda, which is equally exciting. So, it starts off with an update from CMS about the Meaningful Use attestation. And for those of you who previewed the slides it's really quite an uptick and as Judy mentioned there's a significant movement in the field and I think a lot has to do with HITECH and the kinds of health reform issues that are coming down the road. So, this is really good news and we've just go to press forward, as Judy mentioned.

Secondly we're going to hear about the health innovation challenge put out by CMS. As you know, they have an enormous $1 billion challenge out there and the whole CMMI; Center for Medicare Medicaid Innovation Center has a number of very interesting and thought provoking and innovative ideas. So we're going to hear more about that after the Meaningful Use update.

Then we're going to hear from Joy Pritts about the privacy and security activities in ONC and there are a number of areas they're working in and so we look forward to that update. So, following lunch we're going go back to our Privacy and Security Tiger Team, they're going to deal with security and in particular what's changed in the 15 years since HIPAA was around and things have changed and how do we reconcile those things with the new ways of thinking about security and the new needs. And then we're going to conclude, as Judy mentioned, with some activity that was actually called for in the ACA that a combination of NCVHS and the HIT Standards and Policy Committee are supposed to address and provide some advice. And fortunately NCVHS has taken a lead on that and we're going to hear from Walter Suarez and Judy Warren on the activities, the effort that they've put forward and they're trying to consult with both HIT Standards and HIT policies as called for in the statute. And we'll conclude, as always, with public comments.

Any changes or comments on the agenda? It should be very interesting. So, now I would like to entertain a motion to approve the minutes.

M
Move to approve.

Paul Tang – Palo Alto Medical Foundation
Any second and any further discussion? Corrections? I have a couple of attribution edits I'll pass onto Mary Jo. All in favor?

M
Aye.

W
Aye.

Paul Tang – Palo Alto Medical Foundation
And opposed? And any abstention? Very good. Well thanks very much. So we'll begin our agenda with CMS and I think it's Robert Anthony that's going to be talking?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Rob Anthony are you on the phone?

Robert Anthony – Centers for Medicare & Medicaid
I am on the phone. Can everybody hear me?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Yes.

M
Hello Rob.

Robert Anthony – Centers for Medicare & Medicaid
Can everyone hear me?

Paul Tang – Palo Alto Medical Foundation
Yes we can.

Robert Anthony – Centers for Medicare & Medicaid
Okay. Great. I am doing this on the phone so I am following along on the slide's here. Hopefully, as I indicate next slide somebody can advance for me on your end. I'm sorry that I wasn't able to be there in person today and Rob Tagalicod is also sorry that he is not able to attend, but as both Judy and Paul indicated, the good news is that there's very good news. So, if we'll move onto the next slide.

So this is an overview of where the registrations stand for November. In the month of November we had just a little bit short of 24,000 EPs and hospitals that came in to register, that brings us into a total year to date of a little over 150,000 eligible professionals and hospitals that have registered to participate in the Medicare and Medicaid EHR incentive programs. We continue to see this uptick in registration and a little later I'm going to show a chart that puts this in context of what it looks like month over month. Next slide.

When we last spoke in September and we gave an update of where we were status-wise, we were looking forward for the program as a whole to breaking the $1 billion barrier. We were looking forward to $1 billion dollars in payments. We are at the point where we have almost paid out $1 billion in Medicare incentive payments alone. We are looking at this point in time of closing in on the $2 billion mark, very good news. In the month of November we paid out a little over $76 million to over 4200 eligible professionals for Medicare payments alone. We paid out over $300 million in Medicare payments to hospitals, almost $400 million in November alone for Medicare payments bringing the grand total year to date to $920 million. Next slide.

Everybody remembers my pie chart. This is a breakdown of Medicare EPs by specialty, again, not terribly surprising what we're seeing here. This is essentially the same breakdown percentage-wise as we've seen month over month. No surprise that family practice and internal medicine are high on the list. That other category, which is fairly sizeable represents either specialties that had not reached enough of a level to be represented with their own slice of the pie at this point or could be eligible professionals who don't have a specialty that is actually indicated within our PECOS system, which is how we derive specialty, but again, the good news is we're continuing to see in specialties where we thought that there might initially be some issues with participation such as podiatry and gastroenterology, we are seeing EPs continue to participate in that. Next slide.

I want to emphasize that all of our Medicaid numbers right now are estimated numbers. We'll be publishing final numbers in our monthly report on our website and hopefully that will go up in about a week, but we do have some estimated numbers at this point in time to let everybody know where the program is. It's about 2500 eligible professionals in November were paid for adopt, implement or upgrade

payments, that's about $54 million for Medicaid, and around 178 hospital payments totaling around $149 million, so a little over $200 million in Medicaid payments made in November alone and that brings the year-to-date payments to about $916 million. So, again, as we look to the totals and we can go to the next slide.

We're seeing a really positive trend here. We're very excited about what we're seeing. It wasn't that long ago that we were having conversations about the small number of people that we had and the lower number of payments that we had and now we're really starting to see an influx of people. So, at this point, we've got about $1.8 billion in incentive payments made. We do see the numbers continuing to go up and we estimate that December, January, and February are going to be some fairly sizable months for EPs who are coming in and attesting. So, we do expect to see an increase in the 2011 payment numbers as time moves forward. We can go onto the next slide.

This is just a general indication of where we're seeing monthly payment amounts. We started obviously in January, February, March and April; we were just looking at a small number of states that were on-boarded that were making AIU payments. It was really in May where we see our first big bump that Medicare began to pay and then as more states have on-boarded and as we've seen more hospitals and providers come we've obviously seen a real take-off from September when last we reported on the payment amounts.

But the real news, next slide, I think is the number of providers that we're seeing come in and attest and get paid each month. Obviously, the first few months of the year is just the Medicaid and AIU, but we've seen since May, a very steady uptick and since October alone a big jump in the number of eligible professionals that have come in. I do know that we have seen a very steady uptick even now in December. I know that we were talking just yesterday that we saw a very big jump in numbers in just a single day. So we're very excited about seeing the numbers as we move forward. We're very excited about the number of eligible professors that are jumping on board at this point in time and we really think that we're going to see, because eligible professionals can register and attest for a 2011 payment up until February 29th of next year, we think that we're going to see a real influx of people coming in. Next slide.

The last time that we had spoken in September several of the committee members had asked for sort of some context about where the numbers of participants and registrants and people paid fit into the entire universe, the total number of EPs and the total number of hospitals. So, I wanted to give a breakdown of what the total number of EPs looks like. So, you'll see here the big slice of the pie. Here is Medicare eligible professors, that number is about 382,000. The red slice of this pie represents, which is about 95,000 EPs, represents EPs that would be eligible to participate in either the Medicare or the Medicaid Programs. When we did estimates in our Stage 1 final rule we estimated that because of the higher payment amounts in the Medicaid EHR incentive program that those eligible professionals would likely participate on the Medicaid side. And then the green slice of this pie, about 44,000 eligible professional are Medicaid EPs such as nurse practitioners, physician assistants, and a PA lead FHQC that would be eligible for this program, and those folks wouldn't cross into the Medicare side, those are people who are specifically participating in Medicaid. So, the total universe of eligible professionals here is a little over 521,000 EPs and I will show another slide here which kind of shows where we're seeing sort of the end, as it were, of people participating. Next slide.

And then just a breakdown of what we're looking at for the total hospitals. Obviously, the largest amount here is going to be the acute care hospitals about 3600 of them. There are about 1300 critical access hospitals, 78 children's hospitals, and you don't really see this slice of the pie represented, but it is a number indicated there, there are about 11 cancer hospitals. So, the total universe of eligible hospitals and critical access hospitals that can participate in the program is a little over 5000. And if we move to the next slide to set those numbers in context the top part of this shows that at this point in time, with a little over 2800 hospitals registered for the program, we've got about 57% of eligible hospitals already registered and indicating participation.

I put an asterisk next to the paid hospitals number because really this represents a little over 1200 hospital payments made. I don't have a breakout at this point in time of which of those are crossovers,

essentially hospitals that are eligible for both a Medicare and Medicaid payment. So, that 1200 may not necessarily represent 1200 hospitals paid because certainly some of those payments represent both a Medicare and Medicaid payment and we'll try to dig a little deeper for the next time we do this presentation to indicate what that total number of paid hospitals is.

Moving onto the last three lines we're looking at the universe of eligible professionals. We've got about 154,000 EPs registered which is almost 30% of the total number of EPs. We have a little over 21,000 eligible professionals who have been paid under either Medicare or Medicaid so we're looking really at 4% of the market. Obviously, there are others that are on-boarding that have not yet been paid and we're certainly seeing those numbers go up, but part of the reason I wanted to situate this in context of the entire universe of possible eligible professionals is as we move into looking at these Meaningful Use numbers it's fairly obvious that that number of eligible professionals who've actually attested for Medicare at this point in time is a fairly low number. So, we're looking at really around 1.5-2% of the total number of eligible professionals who could be attesting. It's a little difficult to draw conclusions because we really are looking at sort of the earliest of the early adopters, but as I said, we are looking at a number of people on boarding pretty quickly, so hopefully we're going to see a lot more results soon. So next slide.

So, as we look at the data moving forward I think we've seen some of this before. A lot of the thresholds were greatly exceeded, but there are always providers who are right on the borderline of those thresholds as we look at these. I highlighted a couple of areas here such as the most popular menu objectives and the least popular menu objectives. In the most popular menu objectives category, and this would be menu objectives that providers, whether it's EPs or hospitals, are selecting most often, drug formulary, immunization registries, and patient lists are being used most often. And we've seen this sort of month over month. So the 4th month is an indication that those have sort of held steady at the top there. That may be an indication that these are some of the quickest to implement for folks, it may be an indication that for some of the early adopters this is sort of where they're tending. We're certainly going to be watching this very carefully as we move forward to see if that holds true as more people on-board.

Similarly, for least popular menu objectives the transition of care summary and patient reminders for EPs held steady as least popular and again we saw that month over month, with hospitals it is syndromic surveillance that has sort of emerged as one of the least popular menu objectives, although as we've discussed previously when we've gone through this, some of that may be that there are a number of syndromic surveillance registries that really aren't on-boarded yet or available. So, it sort of makes sense that those are being deferred. Again, we're not seeing a huge difference in data between eligible professionals and hospitals; you'll see that as we move through there. And there's not a great deal of difference amongst specialties in performance as far as meeting the thresholds, but we are seeing a little bit of a difference in the exclusions that they take and somewhat in the menu objectives that are chosen. Again, we don't have a huge end yet on the number of EP's in specialties so it's difficult to draw conclusions from that, but that's certainly how we're looking to the future to break down some of this to see what differences really emerge. So next slide.

So again, we're looking at our early adopters. We're not getting a lot of information from this yet on what the barriers to attestation truly are. We're certainly looking at what those barriers are in different ways, we're doing field surveys here at CMS, we continue to talk to a number of the health care professional associations, and we continue to work with ONC to talk about some of the barriers that RECs are seeing, but we haven't got enough here to really indicate what the barriers to attestation might be from the attestation data. At the time of this analysis this represents a little over 21,000 EPs who have attested about 20,800 successfully attested, 444 unsuccessfully attested.

We did have some questions as to what unsuccessfully attested really meant and what we knew from unsuccessfully attested. And really what unsuccessfully attested means is that for one or more of the objectives those EPs failed to meet the threshold. So, we're not seeing anything other than they have entered a numerator/denominator combination that is falling below that indicated percentage. And again, with 444 it's not really telling us a lot about the attestation barriers. We have about 769 hospitals that have attested, all of them successfully, which is a good sign and then we're going to move first here into

the eligible professional numbers, reviewing this in much of the same way that I think that you've seen in previous reviews. So, if we can move to the next slide.

These are the objectives that fall into the quality, safety, efficiency, reducing health disparities domain. So it's some of the recording objectives, which represent recording problem list, medication lists, medication allergy lists, vital signs, demographics, and smoking status, CPOE, electronic prescribing, incorporating lab results, drug formulary checks, patient lists and sending reminders to patients. The performance, again, the reminder here, the performance column indicates the average threshold that they are achieving. So, the average score that they are achieving. The exclusion column, that number represents the number of providers who actually selected that objective as an exclusion and similarly in the deferral column it's representing the number of providers or the percentage of providers that selected that as an exclusion. Where you see a not applicable in the deferral column or the exclusion column it's because in the deferral column those are core objectives and they cannot be deferred. In the exclusion column it's because there's not an exclusion provided for those particular objectives, everybody has to report on them or defer them in the case of a menu.

So what we're seeing is overall pretty high numbers, not inconsistent with what we've seen previously, not a dramatic jump or drop in anything. The recording objectives are all greater than 89%. In fact, as we look deeper into the recording objectives, we're actually seeing a number of recording objectives that are much higher, recording problem lists at 96%, maintaining an active medication list at 97, medication allergy at 96, the lowest threshold is recording smoking status, which is at 89%. About 8% of exclusions here, but it's important to note that 8% is the highest recorded exclusion here and that is in the category of recording vital signs. The rest of the exclusions are fairly low. Smoking, for example, recording smoking status, the exclusion is at 1%.

So really there's not a huge change from the last time we reported this. CPOE dropped slightly from 86 to 85%, electronic prescribing went up from 76% to 77%. Lab results went down from 93 to 91. Reminders to patients held steady at 61. There's not, I think, a lot to infer from those fluctuations at this point because we don't have a huge end here as I say, but the fact that we are holding steady at the same levels, I think probably speaks more to where these early adopters are as far as performance. Similarly, on the exclusions we've not seen a big jump. The CPOE went up a percentage point. Electronic prescribing went up a percentage point, but nothing very dramatic. Next slide.

So, these are objectives that center around engaging patients and their families, e-copy of health information to patients, providing office visit summaries, patient education resources, and timely electronic access to health information. Most of these again we did not see any kind of a large fluctuation on. Again, you know, the patient education resources seems as if, at 48%, it's something of an outlier among these pretty large, pretty high performances, but in fact the threshold for meeting, for patient education resources is actually 10%. So, the fact that the average performance is at 48% actually indicates that these early adopters are really blowing it out of the water in fact. Again, when we look at these percentages, not a big fluctuation. E-copy went down from 96 to 95, office visit from 78 to 77, so on and so forth. A slight jump in the number of exclusions in e-copy of health information, it went up from 64 to 67. I don't know that it is statistically significant at this point in time. Next slide.

And the same here with the objectives of improving care coordination, med rec, summary of care, transitions, we do have both of them at 88%, they were at 88 or 89% last time. The exclusions were both at 2 or 3%. The good news is actually we did see a little bit of movement here in the deferral area. The deferrals were actually pretty high percentage-wise when last time we reviewed this information, med rec was at 74%, summary of care transitions was at 90%, you can see there's been a pretty big drop in medication reconciliation. And a 6% drop at summary of care transitions. I'm not sure at this point in time whether we can call that statistically significant given the number of people that we have on board, but it's certainly an area that we're continuing to watch as we indicated last time because these are really the care coordination and exchange of information objectives that the EHR incentive program is really intending to motivate. So we're hoping that we're going to see this continuing trend of the deferral rates dropping. Next slide.

And these are what the public health objectives for EPs, which is submitting electronic data to syndromic surveillance registry or an immunization registry. The performance on immunizations actually went up from 28% to about 37%. Exclusion rate held fairly steady, well the deferral rate actually went down slightly 26 to 21%, again hopefully as more states are on-boarding here we're going to see more of a performance rate and some drop in these exclusion and deferrals. Syndromic surveillance actually went down from 5 to 2%, it's not terribly significant. Again, I think we know sort of what the reasoning behind this is; there are a number of syndromic surveillance public health agency areas that simply aren't on board in the end. So, it would be harder for a number of EPs to participate in that area. Next slide.

So, now we're moving into hospitals. We're looking at the same area; this is quality, safety, efficiency, and reducing health disparities. We're seeing very much the same type of performance levels and deferral levels as we saw from eligible professionals. Again, all of the recording objectives, problem lists, med lists, allergy lists, vital signs, demographics, smoking status all averaged above 90%. There was a slight decrease in CPOE from 88 to 84, some slight decrease in the amount of deferral or the percentage of deferral for advanced directives; it went from 26% to 16%, but to put it somewhat in perspective, the month before that the deferral rate was at 12%. So, you're seeing sort of a fluctuation that is going to happen, especially as we look at the number of hospitals that we have with 768 hospitals, any kind of large monthly influx is going to cause a bit of a fluctuation in these. The good news is that the performance threshold has stayed consistently high on this. Again, these may be the earliest of early adopters with hospitals so we hesitate to draw any kind of rigid conclusions about it, but we are looking at least a decent number of hospitals, and I think we're talking about 15% at this point in time, so we're definitely seeing a positive trend as far as meeting Meaningful Use from eligible hospitals. Next slide.

Again, we're seeing fairly high performance a very good performance on the patient education resource side, which again has a threshold of 10%, so hitting a 71% performance on the hospital side is very encouraging. E-copy of health information and e-copy of discharge instructions continue to have fairly sizeable exclusion rates. Again, as a reminder part of the reason for that is that the exclusion for both of those objectives is if no patient actually asks for an electronic copy of health information or an electronic copy of discharge instructions. So, again, as we reiterated last time I think that as we see more hospitals on board and as there is more of a public awareness about what patients can actually get and ask for you're probably going to see more of those exclusion rates drop. Next slide.

And then again, on care coordination, we're seeing much the same thing as we saw on the EP side, med rec and summary of care transitions. Performance is relatively high, but the deferral rates on these are also relatively high. Again, I think that as we move forward with some of these things we're going to see a little bit more on-boarding and we'll be able to see more hospitals who are actually choosing these as their menu objectives, but obviously these are some of the harder hurdles to implement at least for these early adopters and we're going to see if that trend continues as we move forward and get more of a critical mass of providers involved.

And then finally the next slide, this is the public health objectives for hospitals. Obviously immunizations are the highest performance here. Syndromic surveillance is higher than it is for eligible professionals but still a fairly small amount; it's actually a minor decrease from 17 to 15% here. The deferral rates did go up a little bit. We do think that because of the number of areas in which syndromic surveillance is available that we're going to continue to see those higher deferral rates. The deferrals went up on immunizations. It's not, I think, with the number of hospitals necessarily statistically significant, we went from 32 to 37. Similarly, the average performance went from 53 to 48 on it, but again we're looking at a small end with hospitals and 180 something hospitals that came in last month and did attesting. So we probably are seeing a big movement in the needle from just folks who came in last month and that may not necessarily be indicative of a trend.

Lab results continues to be a fairly small performance and a fairly high deferral on this. We've obviously had some anecdotal feedback from hospitals that this is not one of the easier public health objectives to implement. So, we may continue to see those same type of performance and deferral rates moving forward, but obviously we're going to continue watching all three of these areas with a great deal of interest to see how this reportable public health data moves forward for hospitals.

So that is all of the good news. I think overall we're looking at a continuing spike in participation. We're very encouraged by the fact that we are closing in very rapidly on $2 billion in payments which we should easily meet by the end of the year and we're continuing to see, for the providers who are coming in and attesting very high performance rates across those objectives and even though this may be indicative of behavior of early adopters, it's something that we're very encouraged by. So, if there are any questions I'll be happy to take them at this point.

Paul Tang – Palo Alto Medical Foundation
Well, thank you Rob it was a very hopeful report in terms of the activity that has been stimulated by this program and we understand that it is still early on, but it's nice to see the graphs trending up the way they are. I have one clarifying question, on your incentive payment. This was where you said paid hospitals and I think you explained that there was both Medicare and Medicaid. What's listed there is 1211. So are those the number of hospitals that have successfully attested and been paid out of the total which would mean almost a quarter of hospitals have already attested and been paid?

Robert Anthony – Centers for Medicare & Medicaid
No the 1211 is actually the number of payments. So there is definitely some overlap where hospitals will have received both a Medicare and Medicaid payment within that. I think probably the better figure to point to at this point in time is the number of hospitals that we had in the attestation. I think I said 768 earlier, it's actually 769. So that's sort of what we're looking at and that represents about 15% at this point.

Paul Tang – Palo Alto Medical Foundation
Good. Thank you and Deven?

Deven McGraw – Center for Democracy & Technology – Director
Yeah, this is Deven McGraw. I have a quick question and it may be that you guys in presenting these results have talked about this previously and I just have either missed it or wasn't paying attention, but we do have a category in Meaningful Use that deals with privacy and security and there is a requirement to attest to doing a security risk assessment. We don't have any data on that. Is there a reason for that? Is that because people just automatically check that box and say they've attested to doing it? And one of the reasons why I bring this up is because it's somewhat relevant to some recommendations we're going to tee up with the Policy Committee later, but I also was privy to some survey results over the last couple of days where a disturbing number of providers anonymously admitted that they were not doing the security risk assessment that they were supposed to be doing. So, I'm just sort of curious why we don't have numbers on that?

Robert Anthony – Centers for Medicare & Medicaid
So we don't have numbers on the objectives that are yes/no objectives because to essentially meet that threshold you have to indicate "yes" to whatever that particular measure is. So having drug-drug and drug-allergy checks enabled for example, everyone has to have enabled that and they would have to indicate "yes." So everybody who has successfully attested will have indicated "yes" on that. So the performance on those will be 100%. The same is true of the privacy and security objective where it is a yes/no indication that you have done that security risk assessment and you indicate yes or no. So 100% of those who have successfully attested have indicated that they have performed that.

Deven McGraw – Center for Democracy & Technology – Director
Yeah. Thank you. I figured it was something like that. Okay.

Paul Tang – Palo Alto Medical Foundation
Of course all of those attestations are subject to audit. Joe?

Joe Francis – Veterans Administration
So this is less a question about the data that you've presented and more about what might be the next level analysis that you're currently doing or maybe planning to do. But certain patterns struck me that,

you know, raise questions that are worthy of inquiry. You know, there's a higher rate among hospitals than eligible providers on capturing immunizations and it strikes me that's probably because it's now a core measure for Joint Commission and wondering to the extent that alignment with, you know, Joint Commission requirements, which impact hospitals more than physician practices incentivize a line, facilitate EHR uptake and it's possible perhaps to go through the whole list of different items at some point and see if that pattern is durable.

The other is a requirement on patient education and my fear is when I see high rates on patient education is what happens to me when I get into the drugstore, you know, they print out something it's so easy and I never read it, and I throw it away and I'm usually so bothered that I sign electronically the attestation that says I've been offered education but I didn't bother. And I know at least one situation where I probably should have taken the time and listened and so understanding a little bit more about, you know, the level of use, perhaps with some qualitative investigation might be helpful at some point and didn't know whether you were contemplating that.

Robert Anthony – Centers for Medicare & Medicaid
No those are both good suggestions. I think that as we move forward we continue to do field surveys on a variety of eligible professionals and hospitals to look at not only those who have not attested yet, those who have not registered, but also those who have and to see what might have presented particular hurdles or the way in which things are used. So, I think there's definitely room to investigate not only the overlap with other incentive programs that may incentivize changes in workflow and quality, but also to take a look at exactly what you're talking about how certain of these objectives are implemented and used. You're right we have a numerator and denominator value that are provided by the provider and that does not necessarily indicate the way in which patient education material is used.

Joe Francis – Veterans Administration
It's a suggestion maybe for a future two-for because I know CMS is revisiting the conditions of participation. You might find a way to get Joint Commission to do some of that work in the field for you and not have to spend any more money.

Robert Anthony – Centers for Medicare & Medicaid
Yeah. That's a good idea. And we're certainly, I think, as we move into Stage 2 and Stage 3 we're taking a look at how some of those other objectives are implemented as well so that we can use that to inform how we develop.

Paul Tang – Palo Alto Medical Foundation
Okay. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So it's great to see the numbers generally increasing even where the percentages overall still are low. So we're making very good progress in the right direction. So this might actually be sort of a drill into some of what's not there yet. It struck me looking at the data and impressions are up for question, which is why I'm bringing this forward, but it struck me that there were both high deferral rates and low performance on measures that had to do with information exchange. Is that just my first impression or is that what you're seeing in the data so far?

Robert Anthony – Centers for Medicare & Medicaid
I think that overall we are seeing that on some of these information exchange. There's no question that what we're hearing both anecdotally and through field surveys is that information exchange is one of the more challenging aspects of this. Challenging in the respect for providers to wrap their arms around exactly how to do it. So we've had a number of questions and issued a fair amount of guidance about that. Challenging in the respect of contacting another provider to be able to do that type of information exchange. That's what we're hearing both anecdotally and through field survey. The question really becomes, does that trend hold? I mean, I think we're looking at that because obviously information exchange is one of the key components of the EHR incentive program. We're trying to figure out as things move forward will there be more of a critical mass so that providers who have an EHR with whom

other providers can exchange information and thereby making it easier to achieve those thresholds, will that number go up and will the deferral rates goes down because of it?

We know in some of the other areas of information exchange such as supplying electronic data to public health agencies that part of it is a question of on-boarding. So we absolutely anticipate that those rates are going to start to go down because states are going to bring more and more of those systems on-line and partially get through some of the backlog that they have of providers that they're trying to get engaged there. So, I think your initial impression is probably not wrong. I think that we're not quite sure what it means yet and it's one of those areas that we're watching as we go forward.

Paul Tang – Palo Alto Medical Foundation
Okay. Final question, Art?

Arthur Davidson – Denver Public Health Department
A quick question, can you tell me if every state has to date had a Medicaid provider or hospital attest or are there still some states that are behind in their ability to receive attestation for Medicaid?

Robert Anthony – Centers for Medicare & Medicaid
Not every Medicaid state has on-boarded with a program yet, I believe we have 37 at this point in time that have on-boarded with their programs. We do anticipate more coming on before the end of the year, we're very excited that California and New York are going live for December and should begin making payments in December. So we're continuing to see more of the states still come online. So, we don't have a provider in every state for Medicaid. I would actually have to go back and check to see if we have a provider in every state who has received a Medicare payment, I'm not sure, again, we don't I think, have enough of an end to start doing a real geographic survey and say, you know, here is an area of the country that is falling down. Primarily because we don't have every state Medicaid agency up and operational with an EHR incentive program yet. So it's hard to point to that area and say we need to concentrate resources here until we really see all of the state programs on-boarded.

We are however already talking with ONC about how we can cross index some of the information that we do with some of the information that the regional extension centers do so that we can begin, as we move forward, to look at those areas of the country and really target where there may be some gaps.

Paul Tang – Palo Alto Medical Foundation
Okay. We're over time. So I want to just keep our questions and our responses short please. I think there was somebody on the phone that we sort of heard, was it Gayle? Are you still on Gayle? Okay, we'll go to Judy and just let me know if there's someone on the phone with a question.

Judy Faulkner – EPIC Systems Corporation
Okay.

Paul Tang – Palo Alto Medical Foundation
So whoever is on the phone we're having connection problems so you might, I don't know, dial back in. Yeah, oh I see, okay, go ahead Judy.

Judy Faulkner – EPIC Systems Corporation
Two comments, one quick question. Like the pie charts a lot that you showed on page 5 that showed the total to the number in the program. Number two, I was on the east coast, spoke to a retired solo practitioner who commented that a lot of the solo practitioners he knows are pretty, I don't know what the word would be, lax about filling out their forms and I don't know how much checking there is to see are the yes's really yes, but I thought that was an interesting comment to pass along.

And the third thing is I thought last time we spoke there was a comment that there would be a list of hospitals put on the website of those hospitals that fit into the having attested and having been paid and I haven't seen it, but maybe I don't know where it is, could you tell us the pathway.

Robert Anthony – Centers for Medicare & Medicaid
Yes. There has been posted last month and it will, as we go forward, continue to be posted on a quarterly basis. We have a new tab on our EHR incentive programs website called data and reports and under the data and reports page you're going to find, near the bottom of that page, a list of providers that have been paid to date in the program. We're required by law to post on an annual basis the names, addresses, phone number of EPs and hospitals that have been paid through Medicare for incentive payments for Meaningful Use. We've actually gotten some feedback from both vendors and the provider community that they'd like to see that list more often so we're going to be posting it quarterly. The last list that we posted last month covers payments that were made through September. We should post another one in January that will cover all the providers paid, under Medicare, through December.

Paul Tang – Palo Alto Medical Foundation
Okay. Well I want to thank you very much Rob for the update and we look forward to it every month because it continues to bring good news.

Robert Anthony – Centers for Medicare & Medicaid
Well thank you everybody.

Paul Tang – Palo Alto Medical Foundation
It'll help us meet Farzad and Judy's goal. Okay. Now we're going to turn our attention to the innovation challenge by Medicare and Kelsey is going to update us.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Good morning. So, I want to start just kind of framing a little bit about where we've been over the past year in development. As we've now been in existence just over a year as an Innovation Center operating. So we've been busy or we like to think we have been and hopefully the market's been feeling that. The mission was set out to be a constructive and trustworthy partner in identifying testing and spreading new models, this is basically taken from the legislation, but really enhanced through Don's leadership and vision that he had set forth for CMS as a whole.

So, the way we think about our work at the Innovation Center is really thinking about a future system and what does that future system look like that we all aspire to not only work in but work for and be an integral part of. And so, there's, you know, different attributes that we all align ourselves with in our various work. So these are some of the attributes that we at the Innovation Center are charged with as we see part of our work unfold.

We look at all the attributes so really through the three part aim and the three part aim being of better healthcare, better health and reduced costs through continuous improvement, which I think has really become a true north for CMS as we have evolved over the course of the past year and continue to evolve in our work as we implement various components of the Affordable Care Act.

So, you know, ONC has actually given us a nice platform to work off of with Meaningful Use and various other, you know, establishments RECs, beacons, etcetera, an infrastructure to build off of as we introduce our work to the market. So, we started out with partnership for patients, really primarily focusing on patient safety. We've also launched Million Hearts another initiative focused on really the ABCs and it's again a cross department effort with CDC. We've also launched the bundled payments for care improvement. We have 4 models that are involved in that, one of which has recently closed and the response from the field has been incredible, almost overwhelming for us to react to, but it's a good place to be.

Medical homes are also an integral part of our work as well as ACOs as I know that folks are anxiously awaiting the announcement of Pioneer's, which we're working through, and then the advanced payment ACO, which was launched in coordination with the Medicare Shared Savings Program last month. We're obviously working towards a global payment system and there's various other, you know, components of our menu, if you will, that are embedded and we'll go through that laundry list right here.

So, the pieces that were left out is innovative advisers program, that's really a program to kind of build an army out in the field for us to leverage. It's going to be at least 200 individuals out in the field working in their respective organizations but having a close connection with the Innovation Center and the Innovation Center's work. So they'll be pursuing various improvement projects within their respective organizations, but that align nicely with Innovation Centers as we unfold our initiatives.

The comprehensive primary care initiative, that was an interesting initiative, it was actually directed more towards payers as opposed to providers and that was one of the first times that we've kind of done a solicitation in that manner and again, we were overwhelmed with the response and I think we can say this relatively publically that, you know, we have a nice representation across the United States.

As part of the Innovation Center work we've also folded in the traditional demonstrations that are still happening and that has become part of our portfolio here at the Innovation Center as well. We're working on three various programs and initiatives with the Office of the Dual Eligibles, which Melanie Bella is spearheading and that is again, you know, dual eligible's account for a huge portion of the money spent and unfortunately really uncoordinated population in regards to the way we deliver care to them. So that's kind of the laundry list initiatives to date that we've been working on.

But the problem with that list is that list is relatively prescriptive when you think about it, you know, ACOs we cut it down to 34 quality measures, etcetera, but it's still quite prescriptive and what we kept hearing from various individuals and various members on the hill, etcetera, is that look we have this great idea but it doesn't quite fit so what do we do? So, essentially we continued to listen. We had over 500 suggestions submitted on-line through our on-line portal and this challenge that we launched, gosh was it 2.5 weeks ago, 3 weeks ago now, has really provided a way for the market to kind of unleash their innovative spirit and tell us what will work for them.

So, there's a few clear objectives in this that are quite specific. One is that we're trying to engage in a broad set of partners in this and really we're looking for a broad set of partners that care for this really critical population of Medicaid and Medicare beneficiaries and perhaps those at the lower end of the spectrum in receiving care and the complexity that they're facing. We are also looking for models that are ready to be scaled up within six months of receiving the award. So, potentially these organizations, these individuals have been partnering with various pieces of their community to date but they haven't, again, had an outlet to actually be kind of blown up and had the notoriety that perhaps they deserve.

And thirdly, the objective here is to create a workforce of the future. So, if we think about the delivery system of the future, we also need to think about what's going to compliment that and whose going to work in it and what is it going to look like. So, arguably, you know, we've seen various organizations come up with community health working programs, individuals who may be high school educated but through a 6 week training program can really be effective in their communities to prevent diabetes, etcetera. So that's another really important part the healthcare innovation challenge.

The challenge consists of $1 billion and that's a lot of money and we're excited about it and the field is excited about it, and so we've received a lot of response and we've done a series of webinars and there will be a couple more webinars that we're offering and because of the competitive grant making process, we have to be somewhat specific and clear about what we can and can't say and unfortunately we can't answer…questions or, you know, provided by various folks and there's a sense of frustration, but we assure them that through the competitive grant making process that they will, you know, rise to the level in which they deserve to based on their respective colleagues efforts.

Part of this grant money will be served to enhance infrastructure. So, a lot of what we see is that there's a lack of registries, there's a lack of various components that could really make a huge difference in the way we deliver and coordinate care, whether it's community collaborative, networks, you know, very specific points that could be leveraged that just aren't because the system currently doesn't pay for this. So, the idea is to really identify those various initiatives that can hone in on those various pieces and test them and then eventually take them to scale. But, again, going back to the importance of the work force impact cannot be understated enough here in this specific initiative.

I think, you know, this has already been covered. It deployed within six months, we're looking for rapid improvement and rapid implementation here as we go to market and compliment the rest of our menu that we have to offer.

An important piece, along with the testing of these various models is how do we sustain this and what happens when the grant money runs out? And that's a huge question that we're being asked every day about it and so there is a component within this that preference will be given to proposals that can be self-sustaining within three years and maybe that's self-sustaining through hospital contributions or various other community organizations that are part of this partnership, but we're really encouraging, you know, public/private partnerships, multi-payer approaches, you know, other complementary service delivery models aside from ACOs and bundled payments, and medical homes.

The selection criteria is pretty straightforward. There's going to be, you know, various points assigned, 30 points to the model design, again this is achieving the 3 part aim. There's going to be 25 points to the organizational capacity. So we're going to look at the organizations history in collaboration with the community in various other, you know, providers, etcetera, that could bring some lift to their credit. The third piece would be 15 points to the workforce component of it. There will be 20 points to the sustainability and financial piece of this, and 10 points to evaluation. The evaluation is a little different; it's going to be a portion of self-evaluation and then an evaluation done by our contractors through the Innovation Center. So, there's going to be a two-prong approach to evaluating the success of the 3 part aim.

This hones in a little bit closer on what exactly the 4 domains that we will be evaluating on and obviously the 3 part aim is front and center of that and then along with operational performance, and I'm sounding like a little broken record here, but the workforce component as well.

When we think about how this is going to really work, we've seen various models that are in pockets of the country and pockets of success are really important, but the ultimate question is how do we scale those pockets to a broader population into various communities and states throughout the country. So we have a portion of our work at the Innovation Center that is comprised all about learning and diffusion. So, for example, through the ACO work we offered the advanced development learning sessions and there were three sessions held throughout the United States to bring in individuals and organization teams who are interested in becoming an ACO. We walked through what that journey looked like for them. We helped them model. We really helped them think through what operationally it would take to become an ACO and the learning and diffusion group will do similar things in regards to innovation challenge. So, as you may imagine we're going to receive, we're thinking quite a few LOIs and then full applications for this initiative and we like to think that we can bucket them in somewhat like categories, whether it's, you know, community health workers or, you know, the hospital collaborating with the local FQHC or, you know, you can imagine these various components, and so to identify the various buckets and then align our learning and diffusion activities with other like organizations that are perhaps proposing the same thing is essentially the high-level thinking to date without seeing any of the letters of intent arriving at our doors to date.

Eligible applicants, it's pretty much everyone with the exception of states. This isn't a state initiative, there will be other work that comes out of the Innovation Center that is more applicable to states, the dual eligible work is somewhat applicable to states, there's 15 states that have been identified to receive design grants through the dual eligible work, but really we're looking for more of these community collaborations with the hospitals, the local providers, nonprofit organizations, maybe even churches, other local organizations that could really help progress the 3 part aim throughout the country.

There are obviously funding restrictions to this. We don't want to duplicate our efforts on the ACO front or the bundled payment front and so we won't be paying, you know, double PBPM costs for their individuals that they're serving. So that is obviously, as we all know, an important piece of this as we move forward.

We're planning on two various cycles because this, you know, initiative came out and somewhat people were excited, but somewhat surprised and said "oh wait we're not quite ready yet. This sounds great, but we need a little bit more time to organize within our community to progress forward." So, we have two planned award cycles, one in March of 2012 and one in August of 2012. Each award could range anywhere from $1 million to million $30 and the first date to keep in mind is the letters of intent for the first cycle, which is March of 2012, are due December 19th and we hope to start awarding those funds or at least making notification to the awardees on March 30th and then the 3 year performance period will end, you know, March 30, 2015 at that point.

This is all of the information that you can go to to identify, you know, all of the letter of intent, very specific in's and out's of the healthcare innovation challenge. And like I said, there are two more webinars coming up and one of them will actually walk through the how you calculate the total cost of care for various populations. So we really want people to take a different perspective than they have in the past and not just think about, you know, what they're operating margin is or what they're census is of that day, we want them to take a much more holistic approach to their frame of mind as they embark on this journey of the transformed system. So, I'll pause there and take any questions at this time.

Paul Tang – Palo Alto Medical Foundation
Well, thank you Kelsey for really a very, very exciting talk. I mean, I like the way you framed it, I mean with the number of CMS program already out the door on top of that you're saying well those have some prescriptive nature of them and here's this billion dollar program that says explain how you can make care better and more cost effective and have at it and I think that's really exciting. And the other thing you pointed out is that Meaningful Use, really what we're trying to put in place is really a platform. I'm not sure any of those folks can do this in a sustained way without electronic infrastructure. So, certainly appropriate for this group. Let me open it up to questions. Christine?

Christine Bechtel – National Partnership for Women & Families
Hi, Kelsey, Christine Bechtel from National Partnership, how are you?

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Hi, good thanks.

Christine Bechtel – National Partnership for Women & Families
So, two questions one is on the infrastructure support and I should start by saying I think there's a lot of excitement about this program and I'm very thrilled to see the real focus on a population that I think needs it most, you know, those with multiple chronic conditions, the frail elderly. I think that's terrific and when I think about that population and then when I think about the presentation we just had from CMS around how challenging some of the Meaningful Use criteria around information exchange and care coordination have been and wondering if you guys are able to prioritize a specific focus on information sharing for care coordination in your infrastructure support component. I didn't see it listed in your examples, so that's why I was asking.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Yeah. I think that's almost somewhat of an assumed function that we have to be able to see across the various caregivers of this respective collaboration, whatever "it" is if you will, that there's going to be some data sharing pieces and I think that's somewhat of an assumed piece on our behalf, yes.

Christine Bechtel – National Partnership for Women & Families
Great. Okay. And then the other question that I have is in your selection criteria, you know, when I think about innovation and I think about designing the kinds of programs that patients and families are likely to accept, that are likely to be sustainable, one of the things I think is most important that these innovators do is have a plan for how they'll involve patients and families in their design and implementation of the program itself. You know, we've just, for far too long been in a position where we're doing things for consumers instead of with them, you know, the HMO experience, right, being one of the most sort of obvious and harrowing in some ways, so I'm wondering if you might consider or if you are thinking about

how having a plan for patient and family partnerships, and a role for them in leading and designing these approaches might be part of your actual selection criteria?

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Yeah, I can't speak to specifics on how it would potentially weigh into the selection criteria, but, you know, a recent example that comes to mind is the importance of the learning and diffusion piece of this. So, as we pull all of these, you know, awardees together similarly when we did with the ADLS for ACOs, you know, we had…come and bring a patient and say what does this mean for me for me to really stir the thinking of how this is going to impact. So, I think your question is right on and hopefully we'll see a lot of proposals that include important pieces such as that.

Christine Bechtel – National Partnership for Women & Families
Thanks.

Paul Tang – Palo Alto Medical Foundation
David Bates?

David Bates - Brigham & Women's Hospital & Partners
So thank you. Two comments, really I think that the Innovation Center has not focused enough on innovation early at the stages of innovation, in particular the requirements and the challenge around being able to scale up within 6 months and also having to include some sort of payment reform basically means that you already had to have innovated and be ready then to scale it up and I think that the requirements are too restrictive and I'm hopeful that the innovation Center will add to its portfolio some things that focus on innovation kind of earlier on. I've had the opportunity to interact a lot with Israel for example, which has made some big investments in encouraging early-stage innovation and there have been an array of really remarkable things that have come out of their experience.

Second comment is that there hasn't been as much coming out of the Innovation Center, as I would like to see, that focuses specifically on IT in innovation and there are just a host of ways that HIT could be used to innovate and something that focused specifically would also, I think, you know, be a nice addition to the portfolio.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Thanks David. In regards to your first question of being too restrictive. I appreciate that and I think that the notion of having two cycles will hopefully help kind of counterbalance some of the upfront restriction to become scalable within six months and it'll give an opportunity to organizations who aren't quite as ready for this first round to partake potentially in the second round after they see what types of, you know, innovations we do fund moving forward. In regards to your second HIT question, it's funny that you mentioned that, I think we talk to Farzad every other week now about how to really leverage not only their work but how to instill HIT more closely within our work. So much appreciated. Thank you.

Paul Tang – Palo Alto Medical Foundation
Joe?

Joe Francis – Veterans Administration
So I'm curious, the rather low waiting on the proposal review for evaluation, particularly in light of your goals to try to design innovations for sustainability and spread and also, you know, just past experiences where, you know, a local innovation project looks like it creates savings or better outcomes through disease management, case management, whatever and yet those findings time and time again have turned out not to be durable. Is that something that the contractor is going to get more heavily engaged in or is that going to be something you're going to look at in the design part of the initiative. It seems 10% seems very low if you want to do something that will endure beyond your funding period.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Absolutely. I think it's going to be a two-prong approach exactly what your last comment of or is it going to be, you know, the first part or the contractor is going to have a heavy hand in it and it's going to be

both. So we're really focusing on what is the organization going to propose for their evaluation metrics and that's what that score is going to be based on knowing that there's going to be a hand over here that is going to be watching and participating very heavily in the evaluation to help compliment theirs.

Joe Francis – Veterans Administration
Yes and I would also suggest that maybe you incorporate that into the design piece too because there are designs that lend themselves more readily to evaluation like, you know, a step-wedge design or a phased rollout that will allow you to do in-situ some control comparisons.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Great. Thank you.

Paul Tang – Palo Alto Medical Foundation
Good. Josh?

Joshua M. Sharfstein – Department of Health & Mental Hygiene, Maryland
Thanks. I'm with the State of Maryland. We're all very excited about the opportunity and there is a tremendous amount of enthusiasm. One question I had is, you know, states can't apply, I'm aware, but you also want public/private partnerships. So, how do those two things intersect? So a lot of people are coming to us saying we want you to be a partner because we can, for example, start to think about sustainability with our payments mechanisms in Maryland and other things, but, you know, on the other hand we don't, we're not, you know, we're supposed to be a step away. So how do you reconcile those things?

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Right. So, I think there's a notion to really involve other public entities whether it be, you know, a university, an academic medical center that is not receiving money directly from like the state health department. So there's other avenues to create this public/private partnership that may not be directly with the state, keeping in mind that the Innovation Center is working very hard on another state initiative to help, I think, align more closely the payment piece to the state approach as well.

Joshua M. Sharfstein – Department of Health & Mental Hygiene, Maryland
Okay. Thanks. I have no further questions.

Paul Tang – Palo Alto Medical Foundation
Kelsey, it was a wonderful presentation, very exciting program so thanks for sharing that with us.

Kelsey Gowin, MPA – Centers for Medicare & Medicaid Services – Innovation Center
Thank you.

Paul Tang – Palo Alto Medical Foundation
So next we are going to hear from Joy Pritts with an update on the Office of The Chief Privacy Officer and a number of the privacy initiatives underway.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Good morning. We're here today to give the committee a brief overview of some of the activities that are going on within the Office of the Chief Privacy Officer. We do work in my office that I often classify as being the big "P" policy issues and more the smaller "p" policy issues that address our internal program. So we are going to give you a little bit of a taste of what we're doing in both of these areas today. This is not our entire workload, as you can imagine, but we wanted to give you some of the highlights.

So we'll start out by introducing you to some of our recently launched projects. I'm just going to list them here quickly and then we'll go and discuss each one in turn. We have the Data Segmentation Privacy Initiative, E-Consent Trial Project, the mHealth Privacy and Security Research Project, Privacy and

Security Consumer Attitude Survey and some of the Security Technical Assistance that we offer grantees through our programs.

We're going to start with the Data Segmentation for Privacy Initiatives and this program actually, and much of the work we do, I think you will recognize as having originated in recommendations that came from the Tiger Team or specifically from this committee. So the Data Segmentation for Privacy Initiative originated from the hearing that was held in June 2010, I believe, on the technology that would enable the electronic implementation of patient choices. We had heard a lot about how, you know, there was a lot of technology out there right now that allowed people to send some of their health information but not all. So, we had an all-day hearing to investigate that proposal and found out that there was some truth to it and also that there were a lot of challenges present in it. We have focused our work on enabling the electronic implementation of existing requirements, laws that exist. We are not really exploring what the policy should be; we are looking at policies as they exist and seeing how you can implement these electronically.

So this project is being led by Scott Weinstein of my office, who unfortunately can't be here today because he is chairing one of the meetings on this very project. We are working very closely with the S & I framework on this issue. As a matter of fact, this issue is housed within them and it is a joint project between my office, the Office of the Chief Privacy Officer and Doug Fridsma's office. You are all familiar with the framework and how it works, so I will just highlight very quickly, for those who may be listening and aren't familiar with it, that there are a number of phases to these projects. There is a pre-discovery phrase where we have meetings and get some of a charter. This is all done very collaboratively with outside stakeholders. This is ONC and S & I. We chair these meetings, we facilitate these meetings, we help guide the meetings, but the meetings and these projects would not be successful without the input of dozens, if not in some of these initiatives, literally hundreds of volunteers.

So the phases go through pre-discovery, discovery, where they create the use cases and user story, implementation, where they all actually look at the harmonized specifications and create reference implementations and the documents necessary to pilot stage, where they try these things out and make sure it actually works, to evaluation as to whether the S & I, the standards that have been assessed during this process and were actually tried in real time are things that are going to work in real life.

So, here we are focusing on, as I said, enabling the implementation and management of disclosure policies that not only originate from the patient but there are some laws in place that say you may not send this information without the individual's choice and some organizations have their own choices too. The scope of this has evolved over time. The project is committed to testing the Standards Committee recommendations on the privacy Medidata tags as part of this component. So, we are trying to, this is something that we continuously call out in this project is that we want to look at all the standards, but this is an essential piece of this project is that we need to test these because we promised that we would do this.

And the outcome here we hope is to be a successful pilot of privacy protection prototype that's compliant with the Federal Privacy and Security Rules across multiple systems and demonstrating interoperability and ultimately an assessment of the applicability and the adequacy of the Standard Committee's recommended standards with respect to privacy and this area. So this is a challenging project getting the scope down to something that's manageable, finding a use case that will address these in a manner, as you know, with a lot of the standards and interoperability work, trying to find that right level of a use case where you're not so far down in the weeds that it's not going to be generalizable has been a little challenging, but we are very optimistic that this project is going to produce some very valuable results. It is being chaired through the Standards and Interoperability Workgroup through Johnson Coleman who many of you may recognize as having been very instrumental in HITSP and the standards development processes there. So he's very familiar with this.

Since we've already spoken a little bit about the PCAST issue here we'll just go to some of user stories that have been proposed, information related to substance abuse treatment, which is given heightened protection under the law. One of the reasons that this issue is being focused on is that it's a need that

has been voiced by many providers and also under the administrations initiative to make sure that more behavioral health information is actually incorporated to the extent possible in primary care records and in order to do this you need to have the individuals permission to do it. Also, there is another requirement out of the HITECH Act where the patient wishes to restrict payer access to data related to treatment received and pay for it out of pocket. This is a statutory requirement, so this is another potential user story that may be examined here, because it is a required implementation. This project has been ongoing for about three months now and is on target to date and we will be happy to provide you with an update on it at a future time as it continues to gel.

Our next project that we're going to discuss is the E-Consent Trial Project and I will turn this discussion over to Kathryn Marchesini who is with my office, she is a policy analyst in my office. She has been with us since almost when I started and we are extremely happy to have her working with us and to have her heading this project.

Kathryn Marchesini, JD – Office of the National Coordinator for Health Information Technology – Policy Analyst

Thank you Joy. Today I'll talk briefly about one of our new projects, as Joy mentioned, the E-Consent Trial Project and just to start off, as you probably know one of the key goals of the Federal Health IT Strategic Plan is to inspire patient trust in health information technology, as well as electronic health information exchange by protecting the confidentiality, integrity, and availability of health information. Informed patient choice is one way to ensure trust with patients, a trusted relationship when moving forward with electronic health information exchange. Similar to data segmentation, this committee actually put forth individual choice recommendations to ONC and one of the emphases was on meaningful.

So, to operationalize on the strategic plan goal, as well as the recommendations from the HIT Policy Committee our office initiated the E-Consent Trial Project. The focus of the project is on education, collection, and evaluation of patient choice in electronic health information exchange. This includes educating and inform individuals of their option to make a choice as to whether they can share their health information electronically. Also ensuring individuals are knowledgeable participants in decisions about sharing their health information while within the clinical environment, as well as electronically obtaining and recording the meaningful choice that the patient prefers.

We use the health IT Policy Committee recommendations as a guidepost to shape the project objectives. In particular, your recommendations noted that the patient should understand how information will be shared and with whom as well as the potential consequences of deciding whether or not to share health information. Your recommendations also noted that it's the person who has the treating relationship with the patient that has the responsibility of educating the patient regarding how information will be shared and with whom as well as obtaining and then tracking patient choice. And, lastly the recommendations put forth, by this committee, say that ONC should provide resources and educational materials to providers to demonstrate and implement meaningful choice for patients.

So, having gone over some of the key project objectives, in order to achieve the objectives we plan to gather patient input throughout the design and development process and this going to include a phased approach using patient surveys as well as focus groups. We will design and develop both educational content based on key information desired by patients in an electronic interface for patients to be educated regarding their choice selection. We plan to also provide flexibility in the delivery of the educational materials to patients which will allow them to make the meaningful choice and overall, similarly to the data segmentation project, as Joy mentioned, the project will electronically implement existing patient choice policies. The actual E-Consent pilot will be deployed in the Western New York Beacon Community Health Information Exchange. There are some existing candidate sites that include large hospitals, small family practitioners, radiologists, inner city health facilities, and large medical facilities.

So, as a result of the planned project activities, over a period of 18 months we hope to identify best practices that ensure that any choice that patients make with respect to sharing their health information are meaningful, that patients understand the consequences of their choices and they better understand

their choices regarding whether and when their provider can share their health information electronically and this includes sharing it with a Health Information Exchange Organization.

So, that's a little bit about our new, kind of, E-Consent Trial Project. I guess I'll now turn it over to my colleague, Penelope Hughes who actually, she'll discuss another project we have going on with patient preferences and health information.

Penelope Hughes, JD, MPH
Thank you Kathryn and I'm a contractor working for Joy Pritts over at ONC. My name is Penelope Hughes and so I'm going to talk about the work that we're doing, the research we're doing on mobile health in privacy and security. And just when I'm talking about mobile health or mHealth in the context of this project we're looking really broadly and so we're really looking at any communication of health information using a mobile device. So, things like Skype or text messaging, we would be looking at that, also using your phone to send an e-mail or using health apps on a Smartphone. So it's a really broad view of mHealth that we're looking at.

And just for background, this project grew out of the text for health task force in the secretary's office at HHS and they were looking at text messaging and health interventions and they identified privacy and security as a really critical issue that needed to be explored and they put forth some recommendations that specifically called for more research on privacy and security in the context of text messaging, and also looking at mHealth more broadly. And those are available at that link there in the PowerPoint. And so what we're hoping to do with this project is to conduct a series of focus groups related to mHealth that really explore consumer attitudes regarding privacy and security issues. So looking at their privacy and security related concerns, and then also looking at some of the safeguards that might make them feel more comfortable.

And, so here is just more detail about how the focus group project is going to work. We're going to conduct 24 focus groups in 5 different regions of the country. So it's pretty diverse. And we'll be looking at urban areas as well as rural areas. We are making an effort to include underserved populations in these focus groups, that was a priority for the text for health taskforce and then also because this technology has the potential to reach underserved populations it's important that they are included. And we will be having some focus groups in Spanish and we are dividing the focus groups up by age because we know that the different age groups use mobile devices differently and would have different opinions about that.

And so the team we're working with, and it will be conducting the focus groups, they are health literacy experts so we're also taking that into account as we conduct the research. And then, so what will come out of this, additionally we're forming an expert panel to review the analytic findings and to provide guidance as we interpret the data from the focus groups. And so we will be producing a final report and with this data and resulting report we are hoping to identify some key privacy and security issues in the area of mHealth as well as explore potential safeguards and we will use this to inform policy discussions around this issue which is a growing issue, and the results will also be useful in informing future surveys or research around mHealth or HIT privacy and security in general and then we'll also inform HHS programs that are related to mHealth.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Thank you, Penelope. A broader consumer attitude survey is also being conducted under OCPOs purview and this grows out of our Federal Health IT Strategic Plan, again, which calls for engaging consumers and inspiring trust in health IT. One of the metrics for my office that has been established is to evaluate whether as we're greatly increasing the sharing of health information, whether public attitudes are going to change about privacy and security and that's pretty much what this project is designed to do.

Given the time constraints, I'd like to leave a few minutes here for questions. I'm going to go through this fairly quickly. It is designed to; it's a broad-based survey. We looked at a lot of prior surveys that had been done in this area so that we could have some trending information over time and the goal here is to

identify changes, if any, in consumer attitudes over time as we really do ramp up health IT and Health Information Exchange.

The project is being conducted using random digit dial, national survey of 2000 adults exploring their views on privacy and security of EHRs in general and Health Information Exchange and the plan is to have this conducted over 5 years. Given current budgetary constraints, we recognize that it may not be feasible to conduct this entire survey repeatedly over that period of time as we're facing tighter and tighter budgets. So what we did here is we built in a plan B if our budget constraints don't allow the full survey and that included collaborating with the National Cancer Institute to field our core questions in their ongoing Health Information National Trends Survey known as the HINTS survey. So, even if our budget does suffer going forward we will still be able to have our core metrics measured over this period of time.

The core metrics include how concerned individuals are with the privacy and security of their medical records; you've seen these questions over the years, so they shouldn't surprise any of you, whether the individuals have withheld information for a provider due to concerns about privacy and security. And do individuals want providers to use their electronic health records and exchange their information electronically despite any privacy or security concerns they may have. So, this last question is aimed to get at the issue that people often do voice concerns and they do a mental weighing in their own head of does the benefit of this outweigh the concerns I have and that's another element that we're trying to get to through this survey.

We're looking to get qualitative data regarding this information, which we're hoping will give us a good finger on the pulse of where we are on these issues and we intend to publish a final report. Moving to the security technical assistance that we're doing, most of this work right now is being led by Deborah Lafky in my office. She has been joined recently by Will Phelps who is another security analyst that we have now on-board and shortly will be joined, in December, by a security manager position. So, we are significantly ramping up our personnel on the security side. It has taken us a little longer than we would have liked, but anybody who has been involved in the federal hiring process I'm sure can understand what we've been going through, in spite of great efforts to simplify that process.

What we are primarily focusing on in providing our technical assistance currently and in the upcoming year, is Meaningful Use Stage 1. What we do not want is we do not want to hear that providers and critical access hospitals perceive having to do a security risk analysis as being the barrier that has prevented them from reaching Meaningful Use and so our goal is to make this process as easy as possible. As you all know, because a lot of this originated in this committee, the risk analysis requirement is that people who attest, organizations that attest for Meaningful Use must attest that they have conducted and reviewed a security risk analysis within a period of time prior to when they sign their attestation for meeting Meaningful Use requirements.

So, our objectives originally were, having worked with our programs, to provide the necessary information for the Regional Extension Centers to go out and assist the providers in accomplishing this. And this is a goal that we have had to adjust over time, because what we have found out, I think 2 of the important components; one is that the regional extension centers are approaching this issue very differently. Some of them see providing privacy and security assistance to these small providers as a potential ongoing business model and so they're very engaged in this activity. And others see themselves as being in this area for a shorter time and they're scared to death of this issue and so they are looking to provide what I would call the minimum amount of assistance possible to these providers. And it's an ongoing challenge given the budgets that they have to strike that right balance of how much is enough.

So, what we've done here is we've shifted our emphasis from just assisting the grantees to going to really the user level and our goal in this next coming year is really to simplify our materials more so that if a provider is presented with a package saying this will assist you in getting to Meaningful Use, and if necessary that they could conduct a risk assessment pretty much on their own with very minimal help. The other reason we elected to go to the route of, instead of teaching the teacher to teach the actual end-user, is I think that there was a little bit of assumption that providers who, most of whom have electronically billed for years, would be aware of a lot of the security rule requirements and would have

been implementing in this area for a while. And we have found that simply really is not the case, that this is often a very eye opening experience for people even who electronically bill that there is this whole part of the HIPAA rules that they are not really very familiar with at all.

The first thing we are doing is we're trying to, on a very short-term basis, simplify the risk analysis tool so ONC has created, NIST has created in conjunction with OCR, a couple of risk analysis tools that people can use that are varying lengths, and we're working in very short order to bring this down to very plain language so it's addressed more to a Non-IT audience, hopefully within the next few months.

We're also developing security training modules, these are on-line modules, they are geared at key topics in health IT security. These are geared at inexpensive, simple solutions that a provider in a small office could implement; it's all security 101, how to complete your own risk analysis, questions you need to ask your HIT vendor, what to do in case of an emergency, back-up, recovery, those kinds of things. These are intended to be short 15 minute sessions and they're using the game play features, so that it's a slightly different approach it's not just a white paper approach, it's an interactive approach. And we're trying to raise the level of awareness and comfort with health IT security and give some really, like I said, low cost simple solutions to get people headed down the right road. This is going to be long-term process, but we need to start somewhere. So at that point I will turn it over to questions.

Paul Tang – Palo Alto Medical Foundation
Thank you very much. A number of good timely issues. Any questions? Okay, very good. Paul Ergerman?

Paul Egerman – Businessman/Entrepreneur
Actually I'll…why don't you do the other questions first and come back to me.

Paul Tang – Palo Alto Medical Foundation
Okay. Fine. We'll take the other side of the table. Art?

Arthur Davidson – Denver Public Health Department
Yes, thank you for the presentation. I just wanted to get back to the first presentation, the Data Segmentation and the second one about E-Consent and how those two relate to one another. You mentioned that you were going to do some testing in a beacon community, are these the stories that you presented in the Data Segmentation the ones that you're going to be testing out for E-Consent in the beacon community? What exactly will you do? I'm trying to understand a little better how these relate.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
First of all, there in both of the projects I understand that we are coordinating efforts. So they are aware of each other and there is an acknowledge of overlap and even in our, was it a request for, what did we put out on this, anyhow our initial funding opportunity announcement said that depending on the timing of this project that the E-Consent needs to be aware of the development of the use cases. There is not sufficient money in that budget for them to participate as what I would call on a full time basis, which some people do on the standards and interoperability framework, but they are aware of those, they do sit in on the calls. So they are tracking each other and they are presenting us with what they are anticipating their use cases being. So there will be some overlap there, it's not going to be one on one and the timing of these, because of the procurement process, we're not sure whether these standards will be to the point where they will be testable by this E-Consent project.

Arthur Davidson – Denver Public Health Department
Thank you.

Paul Tang – Palo Alto Medical Foundation
Josh, I didn't see your card.

Joshua M. Sharfstein – Department of Health & Mental Hygiene, Maryland

Thank you. You mentioned that part of the public survey would be to figure out what kinds of policies might improve confidence in privacy and security of electronic medical records and I was just wondering whether there is specific policies that you'll be asking about, like what are the types of things that you are going try to assess might give people more confidence?

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
I think what we're really looking for, some of the key things that we we're looking for here are where are people comfortable, where are they comfortable sharing their health information and where are they not. Penelope, do you? Penelope is also working on this and probably has a little bit more information on the types of questions. I need to put you on the spot, but is that accurate?

Penelope Hughes, JD, MPH
That's accurate. They aren't presenting, a few present some different scenarios but it's really more just to gage where they are.

Joshua M. Sharfstein – Department of Health & Mental Hygiene, Maryland
If you find that there's not a lot of confidence or that there are populations that don't have a lot of confidence and there are things that could be done around privacy that might give them more confidence, are there things that are being done that they don't know about that might give them more confidence? It might be helpful to know, because then you'd have partly an answer to that. I mean personally, you know, I get nervous when I read that like some website, like everybody's credit card information got out, that probably wasn't intentional, but it makes me wonder, you know, about putting my credit card in sometimes on different sites and so it's both about the confidence, I mean some component of the lack of confidence maybe the lack of confidence in the product or the fact that the systems may not be secure, that it may not be the doctor who is going to give out the information inappropriately but one of these other things and there maybe things that can be said or done that give confidence to people.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Right. So, there are a number of different prongs that this issue is being pursued on and another prong is being conducted by the Office for Civil Rights where they have a statutory mandate to inform individuals of their privacy rights and in order to do that they are engaging with, you know, trying to find out what materials people want and so we're trying to get, there are a number of different approaches to this and we look at the survey of answering some kind of baseline questions and using those potentially, if you start seeing trends, if you start seeing a dip in confidence or that people are withholding their information, then those are things that tell us we have an issue here, we need to delve deeper into it. And I don't think, the survey won't be the method of doing that because you probably won't get to that level of detail. At that point we would need to decide, okay what do we need to do, what kind of questions would you need to change, what would you need to do to segment your audience to find out what the real problem is here.

Paul Tang – Palo Alto Medical Foundation
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. Joy, as you know we've been trying to do some work on registry development and getting…

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Really David?

David Lansky – Pacific Business Group on Health – President & CEO
Broad acceptance by the participating hospitals and provider groups to share data which is identifiable in order to be useful in a registry and we have just enormous bureaucratic and legal barriers to getting general adoption, a lot of re-writing of VAs and a lot of misunderstanding I think of what is required under

the law. And as I think more broadly about the general issues of data aggregation for purposes of quality measurement and reporting and longitudinal health records and so on, is your office or others in HHS doing any other work on generating guidance to providers that would help them find more appropriate ways of sharing data with these registries or other aggregation structures?

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
That's not currently underway. I would expect that there may be some of that that timing-wise it makes a little bit more sense to wait for that for some of these Affordable Care Act Regulations to come out in final form because they will tell you how some of the key entities that are involved in this process can or may be structured and can or may share health information and then at that point I think that it's probably, the timing is a little bit better there and it'll be more informative.

Deven McGraw – Center for Democracy & Technology – Director
Can I interrupt for a second? I do know that AHRQ has actually funded some work on legal issues regarding registries and I can send you some of those links, it's actually been something I've been meaning to take a look at in more detail and haven't had the time, but it's been an ongoing project for them. How well it's connected into some of this other work and some of the Affordable Care Act initiatives I don't know but it's certainly a good place to start looking and see whether there is some additional work that needs to be done.

David Lansky – Pacific Business Group on Health – President & CEO
There was also a meeting at the White House, the PCAST Team convened on the same subject a few months ago. So there's a lot of percolating but it's not getting out into the community yet.

Paul Tang – Palo Alto Medical Foundation
Joe?

Joe Francis – Veterans Administration
So this was a great presentation and I wish we had like 4 question sessions for each of the segments, but since lunch is coming up I'm only going to make one sort of comment and offer. I know that we have, in the Buffalo area, we're engaged with the beacon initiative there and what we call the Villar initiative and we've also been doing some work in VA with electronic consent for our patient health record and so if there is an opportunity for some interagency collaboration and leverage maybe we can look at that.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
That's a great suggestion. We've actually reached out to the VA to initiate conversations if they're interested in doing a collaborative effort, but as you mentioned we're aware of the Villar efforts out there and from my understanding there is a beacon site that has been also identified as a Villar site.

Joe Francis – Veterans Administration
Oh, I sent your presentation last night to Tim Cromwell if you've worked with him, but we can follow up on that. I was just saying that both the Data Segmentation and the electronic record issue is a huge issue for us particularly with interchange between VA and the Department of Defense, particularly when we might see and active duty soldier who might, for purposes of mental health issues, and he may not want that information automatically sent back to the DoD where his base commander could see it, you know, and we have sort of different standards within our two systems about, you know, how private health information is, but when they're on our soil, so to speak, you know, we treat them like a regular patient and not somebody that's, you know, in a chain of command. And so very, very interesting issues that you're proposals are seeking to address.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
So, just so you known, the VA is very involved in the Data Segmentation Project.

Joe Francis – Veterans Administration
Oh, great.

Paul Tang – Palo Alto Medical Foundation
Good. Judy?

Judy Faulkner – EPIC Systems Corporation
This is very easy to understand so thank you. Just a comment on the key metrics with asking the providers about what their concerns might be. I think it's important to make sure that they do understand that in the end they might be choosing between their health, and even their life, versus the information at some point when they may or not know what that is.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Well we've had this discussion quite a bit over the years and particularly in the Tiger Team, and so that is exactly one of the issues that has raised about, that meaningful choice means that you not only understand who is going to share your information, who will get it, how they will use it, but what will happen if you don't share it. So that is definitely one of the components that's being looked at.

Paul Tang – Palo Alto Medical Foundation
Very good. Marc?

Marc Probst – Intermountain Healthcare
Thank you as well and this an incredibly hot topic, you know, I can follow what the CIOs are talking about because we all ask each other questions on how to solve problems and this is clearly the whole concept of security and privacy are the huge topic right now, much less around how do you implement CPOE, but how do you do security and privacy. So two quick comments. One, there aren't a lot of best practices but there are some. Is there any way to expose those best practices so that we're not continually rebuilding our list of best practices, we share it between us as individuals and CIOs.

And the second issue is kind of around, well E-Consent is what raised the issue to my mind, there are a lot of people out there who are trying to solve that problem obviously right now because it's a huge issue, what's the process either for you to do outreach to get that information or the knowledge that's out there, or for people to bring it into you? Because I think in the innovation discussion we just had and David was talking about technology innovation, there's a lot going on in that particular space.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Well that's a good question because we had our hearing a year ago where we did a whole lot of outreach and we had a portal where people could submit comments, anybody could submit comments and tell us what they were doing on that. So, we engaged in that before we started this project, but your point is one that's really difficult because we have to continue to do that and that's, as I keep telling people with security I'll give presentations at professional associations and you'll get a question like when are you guys ever going to be done with the privacy and security piece of this and I always respond "guess what, the answer is if you're doing your job your never done."

Marc Probst – Intermountain Healthcare
Yeah and Joy it really is.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
And that's the same with the innovation. Things have changed, probably dramatically, in a year.

Marc Probst – Intermountain Healthcare
Exactly. A year ago we were trying to solve CPOE and we weren't working on this problem but I think there's a lot of effort now.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Well that's helpful. There's also, as to where information can be shared, there is internally a lot of the grantees had been sharing information on an internal website and we are currently moving a lot of that out of the internal website into what I believe is called the National Learning Consortium and that is supposed to be a forum where good or better best practices that are developed by the private sector can be shared.

Marc Probst – Intermountain Healthcare
Thank you.

Paul Tang – Palo Alto Medical Foundation
And last but not least the Privacy and Security Tiger Team.

Paul Egerman – Businessman/Entrepreneur
Thank you, Joy, everyone is saying it's a really excellent presentation, so I really appreciate it Joy, and as you know these are some of the topics that had some of the most spirited discussions that we had in terms of data segmentation and consent. So I'm kind of curious, and I think a lot of people, because we had spirited discussions, are very interested in your progress, and so I'm curious when you think you might have some progress on some of these initiatives like data segmentation and what will be the process of updating us in terms of what you're seeing out there?

Kathryn Marchesini, JD – Office of the National Coordinator for Health Information Technology – Policy Analyst
I can speak, I guess, on behalf of the E-Consent Project; we just started the project in October. We have been hitting the ground running ever since. The goal is to actually do the pilots would be in early fall. So in the middle of that we will have the surveys which we hope to launch next month to actually gather patient input and then validate that information with the focus groups. So, as far as kind of update and status reports we definitely can bring that back to the Privacy and Security Team or the HIT Policy Committee as to key elements that individuals identified as things that they would be interested in knowing before they have their providers share health information because from that point the developers will ensure that the educational material that is developed that will be put into the application would capture the actual elements that the patient's identified. So that could be a point in which we could bring some information back.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
And with the Data Segmentation Initiative I believe was intended to be a one year initiative and I'm trying to think of when it actually started, because of contracting issues, so I think somewhere in 2012 we should have some results.

Paul Egerman – Businessman/Entrepreneur
That's reasonable. Thank you.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Pardon me?

Paul Egerman – Businessman/Entrepreneur
I said that's reasonable. Thank you.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Okay. Just as you were commenting on the discussions, our lively discussions, the liveliness of the discussions has not diminished any okay.

Paul Egerman – Businessman/Entrepreneur
The discussions are lively, people are very interested in how this is all turning out and getting those progress reports will be very helpful in terms of just helping us understand, like the real world of what you're seeing and direction you're heading.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Yeah, well, and our challenge has been with the use cases trying to make sure that we get them at a level where we can accomplish something in that time period, because if you bite off too much we will not be able to reach our goal of actually testing the standards out, because if you're really down in the weeds then you're going to get side-tracked by a lot of the semantic issues and things like that so it's a challenge but I think that we are headed in the right direction. We do touch base on that one on a weekly basis to make sure it stays on track.

Paul Egerman – Businessman/Entrepreneur
Thank you.

Paul Tang – Palo Alto Medical Foundation
I just wanted to express the thanks of the committee for a wonderful report. It's very clear a lot of important activities, there's probably nothing more important than the trust that you talked about and there's probably nothing more centered to the trust than the privacy. So, these are very important to us. Could I invite you to update us quarterly? Does that make sense? It sounds like you actually have a fairly quick timeline.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Sure, we'd be happy to.

Paul Tang – Palo Alto Medical Foundation
Yeah. Wonderful. Okay. Thanks again. And that brings us to lunch. We're a little bit late. Could we reconvene at 12:50, Twelve-Five-O. Thank you.

Paul Tang – Palo Alto Medical Foundation
Good afternoon and welcome back from lunch to the HIT Policy Committee where we have a couple updates still on the agenda, one is the Privacy and Security Tiger Team where they have some recommendations for our action and the final agenda item, before public comment is the update from NCVHS on an ACA advisory activity. So we'll begin with Paul Ergerman and Deven McGraw on the Privacy and Security Tiger Team update.

Paul Egerman – Businessman/Entrepreneur
Yeah, thank you very much Dr. Tang. I'm Paul Egerman and we really have an interesting recommendation regarding framework for security protections and I'll start by saying we are a Privacy and Security Tiger Team and we generally say privacy and security real fast and try not to make a distinction between privacy and security because a lot of people think they're the same thing, but they are not and this discussion is really about security and security policy. Oops, I think I accidentally turned off the slide projector.

Deven McGraw – Center for Democracy & Technology – Director
Go forward. I think you went the wrong way.

Paul Egerman – Businessman/Entrepreneur
Yes. I got excited.

Deven McGraw – Center for Democracy & Technology – Director
Our recommendations are…slide.

Paul Egerman – Businessman/Entrepreneur
Perhaps I should start by reviewing my technical qualifications in case that caused a lack of confidence. But these are the members of the Tiger Team and we're very pleased to have all these members and I would point out that there is a slight upgrade to this slide in that we have correctly spelled, Epic, so I apologize that for the last, I hope I can do one apology for the last 200 times where we've presented this and it has been incorrect, but we did try to get it right and after all it is a name that has four letters so it's understandable how we might make a mistake as it's fairly long.

So, anyway these are our Tiger Team members and we appreciate all their work on the security issue and the goal of today's discussion is briefly describe something very important that ONC has done with NIST called a gap analysis and what they've done in the gap analysis is very interesting is basically compare the HIPPA security rule with other common information security frameworks and so that's an interesting discussion and Deven will go through that in a minute and then we are going to making some recommendations that we're going to ask for your approval on. These recommendations are actually related to EHR security and they will be actually recommendations to HHS. So Deven will tell us about the gap analysis.

Deven McGraw – Center for Democracy & Technology – Director
Okay. Thank you, Paul. On our Tiger Team calls on this issue actually had quite a presentation from staff at ONC, in particular Deborah Lafky, who does security policy for ONC, as well as NIST, Kevin Stine who is detailed from NIST to provide assistance to ONC and there were a number of slides that they presented to us and we've tried to truncate them here for you all today to get right to the point. Again, they basically took a look at the HIPPA security rule and compared it to other commonly used security frameworks, which is essentially mapping both the required and addressable specifications in the security rule and looking how well they map to security controls in other frameworks and seeing where there are gaps.

And what do we mean when we use the word security framework? This is definitely an ONC and NIST slide. They are organized taxonomies of security controls that are grouped into logically related families of protection. They include, you know, depending on which framework you're talking about, it might be open standards or proprietary or some mix of both. The HIPPA security rule was actually published really before some of the current versions of the security frameworks that are in common use today, but what ONC and NIST had found was that the other common frameworks had really evolved over time from their earliest iterations, particularly in the 90s, but there was a little less evolution, if not no evolution, in the security rule.

Again, the analysis that they did and some of the conclusions that they drew and based on the gap analysis that they performed they were concerned that the security rule had not really evolved in ways that these other common security frameworks had done. And here are some of the ones that they looked at ISO 27001, FISMA (the Federal Information Security Management Act) which applies to government entities and in particular this publication and people who do this work can rattle these numbers off the tops of their heads, NIST SP 800-53, PCI DSS is the payment card industry standard, CoBIT I forget what it is, HITRUST is a synthesis of multiple frameworks that a number of entities, private sector entities in the healthcare system subscribe to.

Again ONC and NIST really looked at all of these security frameworks but focused in particular at ISO 27001 and FISMA, and there were a lot of commonalities among all these security frameworks. And so this was sort of the conclusive slide that they presented to us in terms of sort of identifying, after that mapping exercise, looking at what the security rule had covered in its specifications as compared to the families of protections in the framework of FISMA in particular for this particular slide. And you'll see that in some areas the mapping is really one to one, 100% coverage in both, in other areas the security rule in the viewpoint of the staff who did this analysis is missing some protections.

So we got this analysis and we were able to sort of ask questions and probe in a little bit more depth, you know, the conclusion of the staff who performed this is indeed that there are gaps between the security

rule and some other commonly used security frameworks. But we really concluded that a detailed analysis of these specific gaps and then coming up with some recommendations to address very specific security areas like boundary protection, just to throw out an example, is definitely beyond the expertise of most, although not all, of the members that we have on the Tiger Team and is really beyond the expertise of most, although not all, members of the Policy Committee.

But we did think that based on what we had seen and what we are understanding of the way other frameworks work and how frequently they are updated that there might be some higher level recommendations on security policy that we could make that would essentially task the staff at HHS to do more of the work of exploring, you know, indeed, you know, are these in fact gaps and do we need to address them and how would we do that? So, we have some recommendations and Paul is going to start us off. There's 4 recommendations on 3 slides.

Paul Egerman – Businessman/Entrepreneur
Great. Thanks, Deven. So, the first recommendation basically talks about security policies need to be responsive to innovation and changes, need to be dynamic. It is interesting what Joy Pritts said before lunch when she was doing her privacy presentation, she said somebody asked her when will you get done and she said well you never get finished with these issues, and that was a great insight, and we think that's true of security policy also. Framework security policy just always needs to change and it says here it needs to be responsive to innovations and changes in the market place and it's just true. I mean the technology changes but we also had a presentation this morning from CMS about some of the innovations they want to do in terms of reducing costs in different health care settings and you use computer systems in different environments you'll have different security issues.

So, first recommendation is just really a statement. Security policy basically needs to be responsive. It needs to be dynamic. The second recommendation is really a recommendation about making sure that the security policy is sort of like responsive, reflective to the needs of the industry. It needs to be flexible and scalable given there is a difference in size and resources of entity. So, you know, you look at the security issues that may be faced by say Intermountain Health Care or by Sutter and you compare that to what might be faced by say a rural hospital or a solo physician practitioner, or compare that to, you know, a large group practice of 400 physicians, those are all different settings, and so you have to have some security policies that are scalable to those settings and also establish sort of what we call the solid baseline of security policies. So, there needs to be a baseline, even though you have to have things that are scalable there needs to be a baseline that is consistently implemented throughout the system and then we have this note here in very small print that says this is currently a general approach to the HIPAA security rule. So this is not necessarily any different than what the HIPPA security rule is saying, at least on the second point.

Deven McGraw – Center for Democracy & Technology – Director
Yeah. No that's correct. One could argue that this isn't ground breaking because this is essentially the approach that's currently being followed and yet we think the idea of creating sort of a consistent floor but then having some scalability for resource constraints remains a good way to proceed going forward.

The other thing that came across loud and clear was that providers really need education and guidance on how to comply with security policy requirements and there is a consistent thread to what we're saying here to some of what we saw in Joy's presentation earlier around guidance for the security risk assessment that's actually meaningful and useable by providers. And we sort of started with a recommendation that says we need guidance. We need guidance. The providers need guidance and they need it from multiple sources and it needs to be understandable and then the Office for Civil Rights reminded us that HITECH actually already requires them to issue annual guidance on compliance with the HIPAA security rule and since that provision was enacted in early 2009 they have issued some guidance on how to complete a security risk analysis and they are, I confirmed this with Joy, they are working with the Office of the National Coordinator on some of the work that they're doing to translate the security risk analysis to providers and to give them tools that will enable them to do this.

And so we think this is very helpful but we also think it serves as just a foundation for the development of more policy guidance and what you ought to do from a counter measure business practices stand-point in order to effectively manage the risks that get identified in your security risk assessment. Again, you know, we're coming close to having security risk assessment maybe much better covered in terms of guidance, but that's just one aspect, it's an important aspect of security, but it's just one. There are lots of other elements for which guidance is needed and ideally it could be included with examples of policies and measures that providers can implement in order to counter, again, the risks that they identify in the risk assessment.

And it also wasn't clear to us, since we didn't necessarily know that this guidance that the Office for Civil Rights had developed, that's quite good, knew that it existed, you know, websites can sometimes be a challenge to navigate when there's a lot of other information on them. Lots of folks that we talked to had not seen it and yet it had been promulgated back in the summer of 2010. So it actually has been around for quite some time. So, clearly when guidance is done then there needs to be a better effort to disseminate it through as many resources as are appropriate and possible. So, through the RECs, through professional societies and even direct mailings to providers about where they can go for help we thought made sense.

Paul Egerman – Businessman/Entrepreneur
Great. And so the other recommendation is about education and guidance and the fourth recommendation simply sort of brings this all together. We're saying that HHS should have a consistent and dynamic process for updating security policies and the rapid dissemination of new rules and guidance to all effected. And then we also say that HHS should begin by evaluating the gap analysis performed by ONC and NIST in more detail. So, we think that should be the starting point is to look at that gap analysis and to create this sort of very consistent and dynamic process, update the policies and to disseminate the new rules. Those are our responses to the gap analysis and our recommendations which we're asking for your approval and comment.

Paul Tang – Palo Alto Medical Foundation
Good. Thank you very much. Comments, questions from the group? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
I have two questions. Thanks for the update and report. I don't know anything about this area so this is just a general citizen's naive question.

Deven McGraw – Center for Democracy & Technology – Director
So does that mean you're glad that we said we're not going to take on these gaps in excruciating detail?

David Lansky – Pacific Business Group on Health – President & CEO
Well I was going ask you, as our sort of expert advisors, you know, how are we doing on security and is this framework and strategy that the agencies have laid out and we are supporting advising sufficient or is there a larger set of issues that we as a Policy Committee should be taking up in this domain, longer term I guess, and related to that as a footnote, have you already talked with Joy and her team about the mHealth survey that they discussed this morning and how that qualitative analysis that they're proposing or undertaking would inform a broader assessment of security in the new environment from what that might mean for the recommendations you have today?

Deven McGraw – Center for Democracy & Technology – Director
I think, you know, David, those are really good points. We have not specifically made those connections and we haven't put them express in the recommendations, but it certainly occurs to me that it would be, on your second point, really helpful for that survey of sort of where patient concerns are on security with respect to storage and communicate using mobile devices to store and communicate health information to be able to inform the development of either rules or guidance in terms of complying with say physical security requirements that already exist in the rule. I actually think that's a really good idea, because there is, we didn't spend a lot of time talking about it, but I know from some of the work that I do that there is, you know, that the tools that are used in mobile devices often cannot be secured very well and yet

patients still often express a desire to use them and how do you bridge that gap and make the policy make sense so you're not advocating your responsibility to be secure with data, but your also not creating obstacles to patient dataflow that's not desirable for the patients and that are creating obstacles to those communications.

In terms of whether there are additional issues that we should take on in security, your first question, I don't know the answer to that. I think it's a good start to say that, you know, taking a look at how the security rule matches up to other commonly used frameworks and having HHS explore that in more detail and creating a process for updating the rule and guidance in getting that out, it's probably the most sensible recommendation that we could come up with, because I actually don't play in the security sandbox as much as others do in terms of sort of sussing out issues that are coming to the floor and HHS always has the option of asking us to explore a particular policy issue that comes to their attention such as through evaluating this gap analysis in more detail that they would ask us to opine on. I mean, the idea to look at this gap analysis didn't come from Paul and me or any other member of the Tiger Team we were specifically asked to hear this research and to provide some, you know, to think about what that meant for good security policy for EHRs going forward. So, I don't know if that's an answer to your question, but we sort of, there certainly isn't anything on the horizon that I'm aware of, but there very well could be things that get teed up by some of these future initiatives that we should be prepared to address.

David Lansky – Pacific Business Group on Health – President & CEO
So, I guess where I was going with both questions was really the empirical information, which I don't, I mean you see the newspaper accounts of breaches and so on and some of them are very stunning and I don't know whether that is beginning to also transpire in the mobile health environment and I guess it will be interesting in theory if we had, a couple of times a year, some data in front of us on what the incidence of breaches and other security violations is that are known and whether or not trends, either in the sort of institutional environment, the ambulatory environment or the mobile environment are cause for concern and therefore whether the frameworks that we're considering are sufficient or we're seeing trends in the deployment environment which raise policy issues for us. And obviously the big concern is public trust and if we're not ahead of this curve we're going to have some disaster and we'll all be troubled by that.

Paul Egerman – Businessman/Entrepreneur
And you raise a number of great issues, David. First your comment it's all about public trust is correct and when you see these sort of security breaches in the news that damages public trust, right? It reduces credibility in everything we do when people see some of these things that happen, but my observation is that most of those breaches, I think almost all of them, are the result of somebody not following the rules as opposed to the absence of a rule. That's just an observation. Your comments about mHealth or mobile devices I'd say those are good comments because it's really an example of the why you need to have a dynamic process because fundamentally not only is that somewhat new technology but how it is being applied is different too. In other words people are sort of using it in very different and new ways which one would think might continue to happen. So it's not like the technology itself is changing so much it's more like the application of it in healthcare is changing and that could have an impact.

My last comment is I feel like I'm making like a disclaimer that you read at the bottom of a report or something, but nothing we said should be construed to be an endorsement or the lack of endorsement in the current security policy. In other words we're not saying necessarily that there's anything deficient, that was not the focus of our discussion. When we looked at the gap analysis there was some debate on some of the gap issues of whether it was important to fill that particular gap, whether that was necessarily important. So it's not like the gap analysis told us necessarily that there's anything wrong with the security rule as it stands.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer

So, David, this is Joy if I could respond just briefly to one of the issues you raised. HHS now receives the breach reports, breath notification reports and as you noted has received a lot of information on them. We do analyze the data that comes in that's how we've been able to identify the fact that most breaches right now are occurring from two sources. The privacy aspect of it is kind of from people looking, snooping at records that they shouldn't, you know, they're authorized to be on the system, but they're in places they shouldn't be, but more on the security front is the loss or theft of hardware, you know, of tapes of machines and we have used that to identify where we need to place our focus given the limited resources that we have.

So that particular issue I think raises two issues. One is clearly they're not encrypting the data and we're exploring a little bit more as to why that is. We're getting some anecdotal information from our RECs and from some of our grantees who can tell us some of the stuff that's going on, you know, very much at the ground level, but that's an area that probably could use some further exploration is so why aren't they encrypting it, is it true, I mean the issue that Deven raised about the mobile technology that, you know, it's inconvenient, it's difficult, I know that has been the party line for many years. I don't know if it's true anymore, because so much of this changes very quickly.

Paul Tang – Palo Alto Medical Foundation
Marc?

Marc Probst – Intermountain Healthcare
Thank you. That was a good presentation and it may be implicit in number four there, but I'm just wondering on the recommendations given the dynamic nature, I think and Joy as you were speaking, those are the two we think right now are the biggest exposures. I'll bet we don't know what the biggest exposure is and it's just how dynamic security is. Could it be…

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
We have a third one.

Marc Probst – Intermountain Healthcare
Well I'm sure you've got 10.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
No, we have a third one, no it's a big one that I think that I'd like to put before you just so that you know what I think the top three are is cloud computing has been sold to a lot of people as being the be all answer to their security issues and it's not.

Marc Probst – Intermountain Healthcare
Right.

Deven McGraw – Center for Democracy & Technology – Director
Well it all depends on the security protections adopted by the cloud provider.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
No. No that's not the only answer though because the end user thinks that they can hand it all off to the cloud provider and you can't.

Deven McGraw – Center for Democracy & Technology – Director
Oh, right, right.

Marc Probst – Intermountain Healthcare
Okay, anyway on the recommendation and again I think it's kind of implicit in that last sentence, but is there a way to make part of the recommendation that someone maintain that gap analysis that we're

continually aware of what the other rules are because they change and I would assume our rules are going to change as well and it would just be nice that someone stay aware, keep that gap analysis so that we understand what's being covered where.

Deven McGraw – Center for Democracy & Technology – Director
So that the consistent and dynamic process for updating policies and disseminating guidance includes basically looking at where other frameworks are landing on a continual basis?

Marc Probst – Intermountain Healthcare
Yeah, because I think the gap analysis is really a good thing.

Deven McGraw – Center for Democracy & Technology – Director
Yeah.

Marc Probst – Intermountain Healthcare
It would just be nice that it was…

Paul Egerman – Businessman/Entrepreneur
It is a good thing. It's hard work. It's like taking things that are written in two different languages and putting them together. It's hard work.

Deven McGraw – Center for Democracy & Technology – Director
That would be an easy add, so, and certainly consistent with the discussion that we had as a team I think.

Marc Probst – Intermountain Healthcare
And this is a tag along, very similar, but I noticed your table focused on FISMA but I'm assuming then you're not meaning to exclude ISO?

Deven McGraw – Center for Democracy & Technology – Director
No. No.

Marc Probst – Intermountain Healthcare
Because ISO also includes standards on document currency and updates and the like, so I think that's a great industry standard to adopt and it's non-federal and others will understand it.

Deven McGraw – Center for Democracy & Technology – Director
Right. Right. Right I think any reference to framework should not be limited to just FISMA, yeah.

Paul Egerman – Businessman/Entrepreneur
Right.

Marc Probst – Intermountain Healthcare
So just a quick comment to reinforce all the good work here, I think it's great when we, in healthcare bring in information experience from other fields, we often tend to get very insular in what we're doing and how we see things, so I think that you've grabbed frameworks that are much broader than healthcare is really, really key both for perspective on what we're doing, to keeping us current with what's happening and I think there's great opportunity here actually to address some of these gaps as we go forward.

Deven McGraw – Center for Democracy & Technology – Director
Well and we can't, you know, take the credit for this analysis, this was really the hard work of staff at ONC with assistance from NIST and it was their idea to look beyond just healthcare security frameworks and have a sense of what other industries were doing as well, and you know, private sector, public requirements were all in their mix. So, I'm sure that they'll be pleased to hear that you think that was a good idea, we did too, but it was their idea.

Paul Tang – Palo Alto Medical Foundation

Judy?

Judy Faulkner – EPIC Systems Corporation
One of the things that I think might be important is to differentiate between purposeful getting to the data wrongly, as you mentioned that's one of the things, and stuff done by accident or I have a few examples, one is a healthcare organization that trains its people very well in privacy and security, people looked at records when they shouldn't have, the healthcare organization itself patrolled that, found it, reported it immediately, terminated everybody who had done that and then was fined at the max and I'm thinking that when we do that are we going to have people who won't then look or report, if in fact the end result is that they're fined to the max? So that was one of my concerns.

And the other one also is again when things are not done on purpose, one thing I read, somebody left something, I can't remember whether it was at the dry cleaners or at a flower shop, it just happened to be they put stuff down and didn't realize they left a CD with it or something like that. Clearly, the error was that the data was not encrypted, but there is a huge amount of expense that the healthcare organization has to undergo. They've got to identify all the patients, they've got to notify all the patients and very often they have to have security and credit checks done by a third party on those patients, it might be hundreds of thousands for years and years and years to make sure no-one is misusing it. So there is a natural fine that the organization has altogether and I just wanted us to put all that into perspective as we look at these things.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, I mean, you know, the regulators have, at least at the federal level, the tools for graduated types of enforcement actions, so, you know, in terms of intentional violations versus ones that are negligent versus ones that are not fully understanding what your legal obligations are, I mean, you know, the penalty structure to the extent that penalties are even imposed, I mean, you know, at infractions lower than willful neglect, which is pretty bad behavior, the regulators, at least federally, the Office for Civil Rights has the option of seeking voluntary compliance.

Judy Faulkner – EPIC Systems Corporation
Some of it is state that I've seen.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, your examples I'm pretty sure I know which ones you're talking about, happened at the state level and we can't control how other regulators enforce their own laws. But, you know, certainly when we talked about this in the Tiger Team people felt like, again, some flexibility and scalability although we didn't necessarily talk about enforcement, but a consistent baseline, because the truth of the matter is, is that while we do have resource constrained organizations the data doesn't get any less sensitive when it's handled by a provider with fewer resources than one who is large. So, you know, I think we sort of really deferred a lot to the agencies, again to sort of take the gap analysis and figure out what that means for policy going forward, but the strength of these recommendations is with respect to lets consistently look at what else, you know, what other frameworks are doing, have a process for updating our own policies and get guidance and education out to providers in every way that is possible and that makes sense so that they understand what their obligations are.

Paul Tang – Palo Alto Medical Foundation
Very good point and very good topic. I think security could well be the other shoe that we haven't talked about, the other shoe dropping. In a sense everybody understands privacy, well understands the need for privacy and appreciates the cost of losing, violating privacy, people don't know as much about the security aspects and as the information, as you mentioned, whether it's a big organization or small, the sensitivity of the information is no different.

One question, maybe it's really to the Privacy and Security Tiger Team more broadly or maybe the Non-Tiger Team is some of the implications of this is a result of us not having comprehensive privacy legislation, the protection of which follows the data. And I wonder if now as more and more data and health data, or one of the sensitive of data types becomes available and becomes shared, and you'd like

to keep it for the purposes it was shared, whether it's even reasonable to think about comprehensive privacy legislation so that the penalties fall to whoever misuses it, whoever they are. Interestingly enough one of the top two that Joy mentioned was let's say theft of machines, like laptops. Well the only people who are going to be punished are the people on the laptop not the person who stole the machine and used it in medical uses unlike banking uses. Is the Privacy Tiger Team or Workgroup thought about re-raising that issue or is that an even appropriate issue?

Deven McGraw – Center for Democracy & Technology – Director
Well, I think it's an open question because we don't act on our own. We act consistent with what our mandate is and we technically advise ONC and we stretch that on occasion to say HHS because there are other departments that have a critical role in privacy and security for health data in EHRs and so we have expanded that on occasion, but I don't know that we've ever gone so far as to leapfrog all the way over HHS and have recommendations that are really, one could argue, directed at congress, you know, personally, that's the sort of advocacy for baseline privacy legislation is something that my organization does on a daily basis, but whether the Policy Committee wants to sort of be bully pulpit on that issue as well, I wouldn't oppose it, but it is a little bit of a stretch from what we've traditionally focused on.

Paul Tang – Palo Alto Medical Foundation
Well it just strikes me we're working so much at the coping mechanisms and coping policies that at least advice, not that they can do it, but is the consideration, because certainly other organizations have asked a department to, you know, advocate to congress about laws that would enable them to do their job more effectively and more efficient.

Deven McGraw – Center for Democracy & Technology – Director
Well, right, and you know, to the extent that we have already asked HHS to open that data environment up by giving patients a view and download function into their records, which means that the patients are going to get that data and then be able to share it and spaces that are not covered by privacy laws, which we took on in our transparency recommendations by saying people should at least be on notice that they're crossing a boundary, not burdensome notice, but some notice and yet, you know, sort of where the protections are for that data on the other side of that fence, on the other side of that boundary, we don't have as much of a direct connection to.

But again, you know, we are in the process, and we may have little time to talk about this, we are in the process, Paul and I with Joy and her team thinking through sort of what issues we would take on in the coming year, in what way can we serve HHS and be of assistance to this issue of building trust in the sharing of health information for appropriate purposes and so in many ways your question comes at just the right time because we're trying to think through what a set of issues would look like, which of course we would then discuss with the Tiger Team and we could probably be in a position to share that and get feedback from the Policy Committee as well about what the next set of issues that we would take on, because I think we've sort of focused on what was immediately needed for Stage 1 of Meaningful Use and Stage 2 as we have conceived it as a Policy Committee and now the Meaningful Use Workgroup is moving to Stage 3 and maybe there's a Stage 3 phase for us as well that sort of looks at bigger healthcare reform initiatives and what are some of the privacy and security challenges that arise and certainly the sort of sector specific protection of health data versus an eco system that is protective could arguably be one of them.

Paul Tang – Palo Alto Medical Foundation
Joy?

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
I wanted to tell you that there is at least a little step forward is included in the HITECH Act which amended HIPAA the statute to say that criminal penalties would apply to people who stole data and things of that nature. So, to the extent that they can find them and fine people who use the information in appropriately there are potential criminal penalties available for that, which is a step in the right direction, clearly shifts some of that responsibility from the covered entities, as you were pointing to.

I also wanted to make, this is a little bit beyond the purview of what this group usually looks at, but I wanted to make you aware of the fact that the administration has been working on what they call a privacy framework for information on the Internet, which goes way beyond health information and there was a green paper that was released last year and having been in Washington for a number of years I'd never heard of a green paper before and I don't know if you have, but what it is, is it's a policy paper that's not quite ripe yet and so it's green, and so now they're talking about releasing a white paper, it has ripened to the point where there will be a white paper released probably sometime either later this year or very early next year setting forth the administration's position on information that privacy of information on the Internet that would establish some baseline privacy protections based on the Fair Information Practices and HHS has been involved in that process and sees this as a potential, you know, safety net.

Paul Tang – Palo Alto Medical Foundation
And Joy the provision in HITECH you're referring to, it's not the one with business associates?

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
That's correct. There's another provision that amended the criminal penalty section of HITECH and it's specifically.

Deven McGraw – Center for Democracy & Technology – Director
That you can prosecute individuals.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Yeah.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
That are not covered entities.

Deven McGraw – Center for Democracy & Technology – Director
Yeah.

Joy Pritts – Office of the National Coordinator for Health Information Technology – Chief Privacy Officer
Or business associates.

Paul Tang – Palo Alto Medical Foundation
Good. Other questions or comments? Very important set of issues so I hope that we can make…so now the group is asking us to adopt their recommendations, the four recommendations you see before you, which is really sort of play catch-up a bit with the HIPAA security provisions in such a way that you can be flexible as HIPAA was in terms of with your resources and the amount of risks that we provide the very important guidance to people who are trying to comply with these regulations, but basically complying with the spirit and that we have a mechanism to keep it dynamic and so that we can continually refresh and then the addition was and to perform an ongoing gap analysis so we don't create such a gap in the future. Is there a motion to approve their recommendations?

M
So moved.

Paul Tang – Palo Alto Medical Foundation
And second? And any further discussion? All in favor.

M
Aye.

W
Aye.

Paul Tang – Palo Alto Medical Foundation
Any opposed or abstained? Good thank you very much. Thanks to the Tiger Team.

Deven McGraw – Center for Democracy & Technology – Director
We're getting better at this.

Paul Tang – Palo Alto Medical Foundation
Yes. Awesome. Well I think Joy absorbed some of the energy about privacy here. Okay so we're going to close our meeting with an update from NCVHS on their activities surrounding the ACA section 10109 and probably a lot of us don't even know what 10109 is, so Walter and Judy are going to help inform us. So watching the time I know you have about 30 slides so we've got to make sure that we get through it in assembly.

Walter Suarez, MD, MPH - Kaiser Permanente
Oh yes. Thank you.

Paul Tang – Palo Alto Medical Foundation
Thank you.

Walter Suarez, MD, MPH - Kaiser Permanente
Thank you very much Paul. Good afternoon. Pardon me?

Paul Tang – Palo Alto Medical Foundation
Is Judy going to be here?

Walter Suarez, MD, MPH - Kaiser Permanente
Judy is on the phone.

Judith Warren, PhD, RN - National Committee on Vital and Health Statistics
I'm on the line.

Paul Tang – Palo Alto Medical Foundation
Oh, great.

Walter Suarez, MD, MPH - Kaiser Permanente
Yes, thank you very much for the opportunity to talk to the committee about some of the work that the National Committee has been doing in this area and some of the opportunities that we think there are to collaborate. Judy Warren, our other Co-Chair of the Subcommittee on Standards is on the phone and she'll be walking through some of the introductory slides and then I'll talk about some of the findings on the specific area that we were called to collaborate with the Policy and the Standards Committee. So Judy I'll turn it to you and I'll be flipping the slides here.

Judith Warren, PhD, RN - National Committee on Vital and Health Statistics
Okay. Let's go to the next slide then. So thank you for the opportunity for Walter and I to talk to you. As Paul said he wasn't sure that many of you knew what 10109 is, it's a provision in ACA that says that our committees need to work together. So, we've taken some initiatives and held some hearings and Walter is going to be explaining the things we found and then we hope after you hear the presentation that we can start looking at how we may collaborate to fulfill the directives that we've been given. With that what you see on the slide is just an outline of our presentation. So Walter lets go to the next one.

This is the slide that's been keeping Walter and I awake at night with NCVHS being given the responsibility to keep on top of HIPAA, to make annual reports to congress about the implementation of HIPAA and believe it or not we're still implementing some of the specifications that HIPAA had as the regulations are still being written and the most classic example of that is the ICD-10 implementation. Next we have Meaningful Use, which you guys have been very involved in. We also have various healthcare reform laws that are being passed and then on top of that all the states are also engaged in a lot of work and our concern is the same people are involved in each one of these implementations at the local level and so it's really providing a burden and yet it's a burden that becomes a challenge to us to take on, because I think Judy Murphy was right this morning this is going to happen and we need to figure out the best pathway. So next slide Walter.

Just a little about the committee and I'm not going to go into this, but we thought you might want a little bit of information about the other FACA committee. We do work in subcommittees to accomplish our work and as we said Walter and I are Co-Chairs of Standards, but we also look at population health, privacy, confidentiality and security so much like your Tiger Team and then the quality issue and I know you have 2 Workgroups on quality. And so there's a lot of coordination that is going back and forth between all of these committees. The next slide.

So, under the HIPAA law we're responsible for me making recommendations related to all of the administrative simplification things such as transactions. So, these are the electronic transactions of submitting bills and finding out other information for reimbursement, code sets, which is what HIPAA called standardized terminology, identifiers, so looking at health plan identifiers, provider identifiers, and then that wonderful one called patient identifier, which has yet to be adopted and in fact probably will sit there for a while, and then standards around security and privacy. Along with that we are responsible for submitting to congress an annual report giving the status of HIPAA implementation and what our evaluation is of the achievement of administrative simplification and so we've just turned in our 10th report to them.

When ACA was passed we were given expanded responsibilities under that law so in section 1104, we were asked to define and recommend a standard for health plan identifier, that one has been done. We were also asked to identify operating rule development entities and so operating rules are those middle ground that take the standard and actually help the business partners learn how to use it and fulfill those rules and so the operating rules are being done, they can be handled a little bit speedier than what standards development is. The entities that we've identified so far have been working also fairly closely with the standard development organizations to make that happen.

And then we get down to actually identifying the standard for electronic funds transfer in healthcare and so we've actually begun working with the banking industry and finding out what standards they're using and then selecting those portions that support healthcare. Finally, were looking at claims attachments. Our task is to recommend a standard and its implementation specifications and then to select an operating rule development entity and approve their rules. That brings us down to section 10109 which requires us to work with the two HIT committees to do a variety of activities. So we need to meet at least every 2 years, monitor the status of standards and operating rules and then recommend any new changes that come along with those. And I think one more slide, Walter.

Okay, so the primary responsibilities we have here from an NCVHS perspective is to identify and review these standards implementation specifications, operating rules that are related to electronic administrative transactions, terminologies, code sets, identifiers, and security measures. We have a monitoring responsibility to where we actually receive annual reports from several organizations and review their work. We review standards, development process and try to streamline that from the time that the standards developed until the secretary can endorse it, which is a fairly lengthy timeframe it's one of the reasons why it's taken us so long to implement things through HIPAA. And then there are a lot of crosscutting issues which I think you're finding as well on your agenda and so we spent a lot of time working with the other three subcommittees. And I think at this point Walter the slides are yours.

Walter Suarez, MD, MPH - Kaiser Permanente

Okay. Thank you so much Judy. So this next slide just highlights basically all the various points of activity that we have. This particular slide talks about the upcoming HIPAA requirements for transactions and code sets that turn to 5010 and D.0 January of this coming year then ICD-10, and then you can see the timeline for each of the points that came out of section 1104 on the Affordable Care Act, a unique identifier, the operating rules and the new transactions. And then on 10109 we were to solicit input and provide additional feedback to possible new areas of standardization and that's what brought us to this point. So, basically what section 10109 said was that the secretary would solicit input from NCVHS, the Standards and Policy Committees and Standard Development Organizations to find whether there would be greater uniformity in financial and administrative activities and items and generally whether there will be opportunities to adopt standards and operating rules that would improve those processes.

And this is more specific what section 10109 asks us to do, focus on areas like enrollment of healthcare providers, whether there were applicability opportunities for all the standards and operating rules through other sectors of the insurance industry and then activities around standardized forms for financial audits and for claim edits. So, we, not unlike this committee, we undertook the initiative to move forward with this and convened a series of hearings earlier last month, I guess in mid-November, to hear from the industry about each of these topics and that's what I'm going to try to cover very quickly here. So, I'm going to talk about, you know, each of these topics, what we heard and what are some of the policy and standard areas that I think we can work together.

Starting with the enrollment of providers, basically the question was can the industry move a uniform process and application form for enrolling providers in health plans. And generally speaking what we heard was that, yeah, you know, there is a lot of processes, there's a lot of repetitive activities, each one health plan has a unique way to enroll providers. There are many reasons for enrolling providers in health plans including enrolling them to their participation in their networks as well as enrolling them to conduct EDI transactions, EFT transactions, have provider directories, identify electronic services that providers are supportive, and basically what we heard at the end of the day was, yeah this is an area where we think it's important to identify some standards. We think that the next steps that need to be taken are to consider developing sort of a general framework on how to handle provider enrollment in health plans in a more consistent and standardized way and considering establishing a multi-stakeholder group to develop such recommendations.

In terms of the policy and standards issues I think we clearly identified some of the areas of implications for the health plan operations from the policy side. When establishing standards for enrolling providers there are, you know, the right roles for standards and operating rules in the enrollment process and there might be some situations where the processes needs to be flexible enough to, you know, allow health plans to handle specific situations for enrolling providers. There is the policy issue of the relationship between the enrollment process and the credentialing of providers and even though the actual focus is really on the enrollment of providers and automating that process and simplifying it, there are some opportunities to consider also the credentialing aspects of it. And then issues around funding and other, you know, policy points.

And from the standards part of course the question was what's the existing standard or existing standards that can be used, are there existing tools that can be used and can there be a provider enrollment database that can be credentialed and mandated to be used. So a lot of interesting questions and I think ultimately from this perspective the idea is going to be to look into more refined types of identification of issues and discussions potentially, again engaging the committees and listening to other recommendations and again the idea of convening a multi-stakeholder group to define those. So, that was the provider enrollment side.

The second topic was should HIPAA apply to other programs or insurance areas, such as workers' comp, the medical component of auto insurance, property and casualty. So, what we heard basically was, well probably not at this time. There are important differences between the various other types of insurance. There were pointed discussions around how in some of these areas claims mean a completely different thing and the participants in a claim are very different from a health claim and so there are different

workflows, different relationships, different terms. There were recommendations again to consider a multi-stakeholder policy group, advisory group to help define better what areas would there be an opportunity for pursuing the use of the standards in these other insurance industries.

Clearly, the sense was there are standards that can be used, there are opportunities for the industry to use those standards and there is clearly a benefit of beginning to use the same type of standards that are used in the healthcare claim side and the administrative side of health insurance into these other areas, but there needs to be some appropriate adjustments of those standards and appropriate changes to ensure that the difference in the insurance types are taking into account.

So, from a policy and standards issues perspective I think we highlighted clearly there is in the HIPAA law some carve out areas for these types of insurance and there is an overarching issue of if they were to become subject to some of this how would elements of HIPAA such as the privacy regulations and the privacy requirements apply to them and what would be the effect in assuring expedited processing and payment of information. Again, clearly there were some important differences in the work flows and the actors that participate in this type of insurance, workers compensation for example and the role of the employer, the role of the individual, the role of the provider is very different than a healthcare claim where the healthcare provider is submitting the claim to a health plan.

Impact of state laws, there are a lot of state laws and regulations that affect property and casualty and worker's comp and those would need to be taken into account. In the standard side the consideration was this concept of electronic billing or eBilling that is using a modified version of the standard issues for healthcare billing and that shows some very promising results and so the opportunity to support that and to expand that into these areas of insurance programs was also a recommendation. All right so that was the point of HIPAA applicability to this other insurance.

The third topic was claim edits and the opportunity to find consistency in claim edits. So, here the idea is that basically every health plan has its own way to take a claim that is coming to them and analyzing it and determining its ability to begin to enter into the education process or reject it and return it. So the question was can there be an increase in greater transparency and consistency in the methods used to conduct and implement these edits. What we heard basically from the industry, there is an initiative under Medicare called the National Correct Coding Initiative, NCCI, which uses proprietary and is really internal to CMS, but many providers found that there were significant opportunities to build and have that and be used as a foundation. Some health plans offer some caveats about using that as a foundation.

There are a few states like Colorado that are already working on efforts to standardize their claim edits within the state and certainly there is significant frustration on the part of the providers as was expressed in the hearings with the inconsistencies in how the edits are being put in place and managed. So, again, a recommendation came through as a way to move us forward with this to identify potentially a nationally recognized group to begin to develop these recommendations for a transparent and credible process, recommended standard edits and establishing criteria, and definition for the recognized sources for those edits on claims.

From a policy and standards perspective we identified a couple of points, transparency between government payer efforts, private sector health plans and providers was a key element. I think there's a lot of concern about the secrecy, if you will, that these claim edits are handled with and the inability to really share those across different organizations and begin to harmonize and standardize some of those, so one area to consider. There's also the opportunity to have standard coding guidelines like CPT guidelines that are currently not adopted under HIPAA that can be considered to be an area to help standardize the use of standard claim edits. And, again from the standards perspective adopting the CPT coding conventions under HIPAA regulations could be one way to help establish some standardization in this area. And then the correct coding initiative, the findings from this National Correct Coding Initiative from CMS could serve as a way to begin to identify areas where this standardization of coding edits and claim edits could move forward.

And then the last item was financial audits and standardization of forms. So, the question here was are there ways to standardize aspects of the current audit activities? These are audits that our providers and health plans are subject to, can standardized forms apply to financial audits required by health plans by federal and state agencies and other relevant entities. We heard basically providers are subject to audits from different entities and they request different types of data, have different requirements, different timeframes, and this imposes a significant administrative burden in the redundancy, in terms of the types of requests is significant. There is also a lack of transparency, cost, administrative costs are high to handle and to respond to these audits.

So, I think from a policy and a standards perspective issue one of the points was the impact that these audits could have in a more standardized way in reducing or eliminating some of the fraud and abuse that exist in the system and certainly there was, from a provider perspective a lot of support for harmonizing and standardizing some of these financial audit activities. NCPDP, the National Council and Prescription Drug Program, has data elements in pharmacy transactions that allow for the protection, if you will, and the exercise of some of these financial audits, automating these financial auditing processes. So, there is already some work being done around that and so there is certainly, again here another opportunity to explore farther the idea of harmonizing and standardizing some of these processes across the industry.

So, finally, some overall observations, I guess throughout this 4th topic there was some consistency in a couple of things. One is we're certainly not ready yet to formulate specific recommendations around any of these topics. We think that there's an opportunity to convene some specialized groups that can develop some of these recommendations and then bring them forth to our committees would be a good way to move forward. So, that's I think the overarching message that we heard throughout the hearings. CMS work certainly in this area is certainly a very critical foundational element.

In the interest of time I'm going to stop here. We also have a few other slides, the next couple of slides talk about the claim attachments, which I know is a topic of significant interest, just a word about that, HHS is required to issue final rules on claim attachments by January 2014 and we had a full hearing on that and there is a lot of connections, a lot of relationships between claim attachments, the attachment to a claim, which is mostly clinical information, and the standards that are developed for the exchange of clinical information under Meaningful Use, for electronic health record systems. So, clearly, there are opportunities to work around this collaboratively as well.

And then the last slide I wanted to show is the opportunities for collaboration. So, indeed in section 10109 we were asked to collaborate, we have taken sort of a leading step and initiative to move forward, NCVHS has, and begin to address these issues and we think that we can work together in three areas, identify policy recommendations based on findings from hearings, identify possible standard recommendations, and identify areas for standardization, beyond those mentioned in the Affordable Care Act and a lot of this work can be done in 2012, again collaboratively between our committees.

So, the next steps with respect to with what we are doing in our National Committee is we're going to be drafting 3 different letters dealing with the observations and recommendations from these hearings and we expect to have those drafted by January of next year. We will plan to distribute those to the committees for input and then we expect to be able to complete that and submit the observations and recommendations to the secretary by February of next year. And I want to emphasize that the recommendations here are not really recommendations in terms of adopting standards or defining policies. I think a lot of the recommendations are going to be more in terms of the types of things that we heard from the industry which is we need much more specified specialized analysis of this and from multi-stakeholder groups that can come back with specific recommendations on whether adoption of some standards would be appropriate. I'm going to stop there and turn it back to Paul.

I do want to say actually one last word which is we do have a more detailed description of the Standards Subcommittee activities for 2012 and highlight of the 2011 and you can read those at your leisure. In 2012 we have a very busy schedule including all the HIPAA related work. We have a lot of work around public health data standards and also a lot of work to be done jointly with the other subcommittees in the National Committee. So, thank you very much.

Paul Tang – Palo Alto Medical Foundation
Well, thank you, Walter and Judy. We certainly appreciate the NCVHS and NCVHS Standard Committee taking a lead on this particular provision of the statue and your work with HIT Standards Committee and clearly we would be willing to participate and comment on your draft letters from a policy impact in the things that relate to the work areas that we get involved in. So, thank you. Any other comments or questions? Well, excellent work.

Walter Suarez, MD, MPH - Kaiser Permanente
All right. Thank you very much.

Paul Tang – Palo Alto Medical Foundation
And detailed work. So thank you so much for doing that both Walter and Judy. Okay any other comments before we turn over to public comment? Okay why don't we open the lines and anybody in the audience who wants to speak?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Operator will you open the lines and instruct people on how to provide comments and in the meantime if there's anyone in the room who would like to provide a comment please come to the table and be sure to identify yourself. So, well take comments in the room first.

Robin Raiford – Advisory Board Company
Hi Robin Raiford from the Advisory Board Company, but I make this comment as somebody who came from the HITSP nation and a shout out to Joy Pritts, where is she? If she's still here, but ONC take it back to her. The significance in this country of Jonathan Coleman joining ONC and the significance in this country to Walter Suarez leading that and all the spirited, spirited discussions that went on the HITSP Privacy and Security Workgroup, I think probably you had Tiger Teams and Cheetah Teams, I think HITSP Privacy and Security, the developers who did that just took it to a new level and Jonathan probably personally wrote every business actor and technical actor in every HITSP Privacy and Security document there is. So, that's a good thing and just a shout out to Judy Murphy and to nursing in this country how significant it is to have a nurse in a leadership role at ONC. Thanks.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Okay, anyone else in the room? Operator do we have anyone on the line or have you given instructions please first? Operator? Do we have the operator?

Paul Tang – Palo Alto Medical Foundation
Okay well we'll join back if any comments come in, but as we close out the year, 2011, I want to thank one the ONC staff, the entire office has been running like a cheetah throughout the year and it's really had a lot of good results so thank you to all of them. Thank you to the committee members for again another yeoman's year in terms of the amount of work put out by the Committee, by the Tiger Teams. A lot of great work and I think it shows. And I think we can count on 2012 being exciting and very productive and busy, and so I look forward to your continued support of this process and to all happy holidays and see you next year.